STATE HEALTH IMPROVEMENT PROCESS

BIENNIAL PROGRESS REPORT

2012 - 2014

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BACKGROUND

In early 2011, the Office of Population Health Improvement (OPHI) at the Maryland Department of Health and Mental Hygiene (DHMH) launched the State Health Improvement Process (SHIP), which is a framework for accountability, local action, and public engagement to advance the health of Maryland residents. The goal of SHIP is to enable communities to identify critical health needs and implement evidence-based strategies for change using a common platform to measure success. As the first phase of SHIP comes to an end, this report looks back at progress to date and considers how SHIP may evolve in the coming years as Maryland's health care system continues to transform.

SHIP MEASURES

SHIP began with 39 health measures in six vision areas – healthy babies, healthy social environments, safe physical environments, infectious disease, chronic disease, and health care access – which are closely aligned with national Healthy People 2020 objectives. For each measure, a statewide baseline and target goal for improvement by 2014 were established. The measures were chosen with input from the public health community and the general public. County-level measures – stratified by race/ethnicity – were also established where possible, and a data dashboard was created to track and report progress on all measures. In 2013, new measures were added to the SHIP data dashboard that better reflect the social determinants of health while other measures were removed or modified as better data became available. Subsequently, the SHIP vision areas were reorganized to better align with Healthy People 2020 and reflect how Maryland communities approach health improvement. In 2013, SHIP consisted of 41 health measures organized in five vision areas – healthy beginnings, healthy living, healthy communities, access to health care, and quality preventive care. This report reviews success in meeting the established 2014 targets for improvement for all these measures. Targets were met for 14 measures and significant improvement was seen in an additional 12 measures. OPHI will release a revised set of measures in early 2015 along with new targets for improvement by 2017.

LHICS AND LOCAL PRIORITIES

Local Health Improvement Coalitions (LHICs) cover every jurisdiction in the state (see Figure 1) and are typically co-chaired by representatives from a local hospital and the local health department. Through the LHICs, community partners have an opportunity to collaborate on identifying and deploying strategies to address critical health needs as part of SHIP. All LHICs produce an action plan each year that outlines priorities and describes strategies to address these priorities. This report highlights LHIC activities in years two and three of SHIP, includes news stories about strategies and improvement activities at the local level, and provides information on the financing of LHICs.

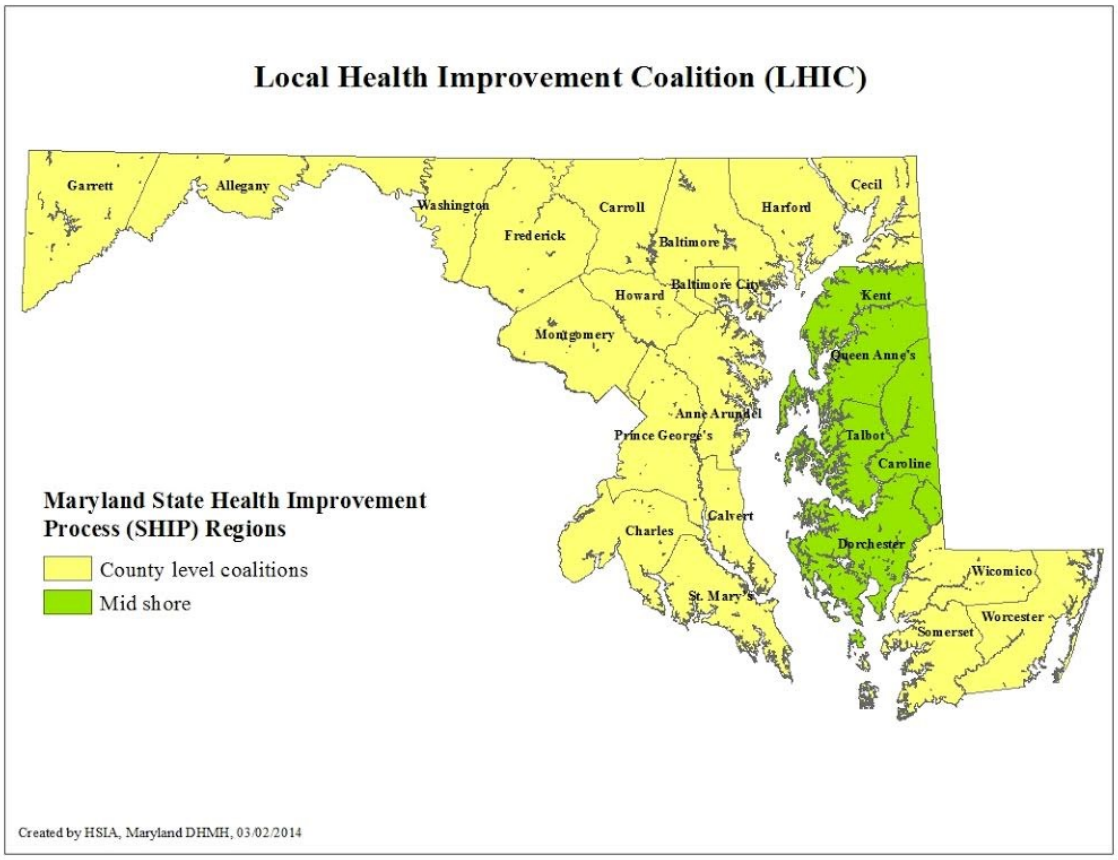
In 2013, nearly all of the 20 LHICs in Maryland prioritized obesity (16) and most had goals to improve behavioral health (9), access to health care (9) and smoking cessation (9). The priorities for Year 2014 were very similar, with obesity (16) remaining the top priority area, followed by substance abuse (11), smoking cessation (9), and access to health care (8). Actions linked to the SHIP 2015 targets included health systems analysis and asset mapping; assessing community risks and needs; educating target groups, partners, and providers; expanding health screening services in community settings; aligning and integrating services; and policy analysis for health promotion. More information on individual LHIC priority areas is in Appendix A.

VISION FOR THE FUTURE

The vision of OPHI is to foster integration of the health care system with public and community health to promote improved health while lowering health care spending. This vision is of increased significance as Maryland's health care system undergoes significant and historic transformation towards a system that incentivizes improved population health. Through the All-Payer Hospital Model, under which all Maryland hospitals are financed via global budgets, meeting SHIP target goals through local population health strategies will help improve hospitals' bottom line. As the tweaks to SHIP measures over the past few years indicate, SHIP is a living process designed to accommodate complex and ever changing health drivers and communities. The next phase of SHIP will include more measures relevant to the All-Payer Model, including additional utilization measures.

In addition, the LHICs are a natural structure through which hospitals can establish strong partnerships to support population health strategies, but their capacity to implement large-scale interventions has been limited to date. OPHI is currently working with other agencies and stakeholder partners to identify opportunities to bolster the capacity of LHICs to engage in a higher level of coordinated community action through sustainable funding streams that align with broader delivery system reform efforts. More information on changes to SHIP related to health system transformation is on page 7.

Figure 1. LHIC Map



Note: Until 2013, Wicomico, Worcester, and Somerset Counties were part of the Tri-County LHIC. They now each have a county-level LHIC.

EVOLUTION OF SHIP

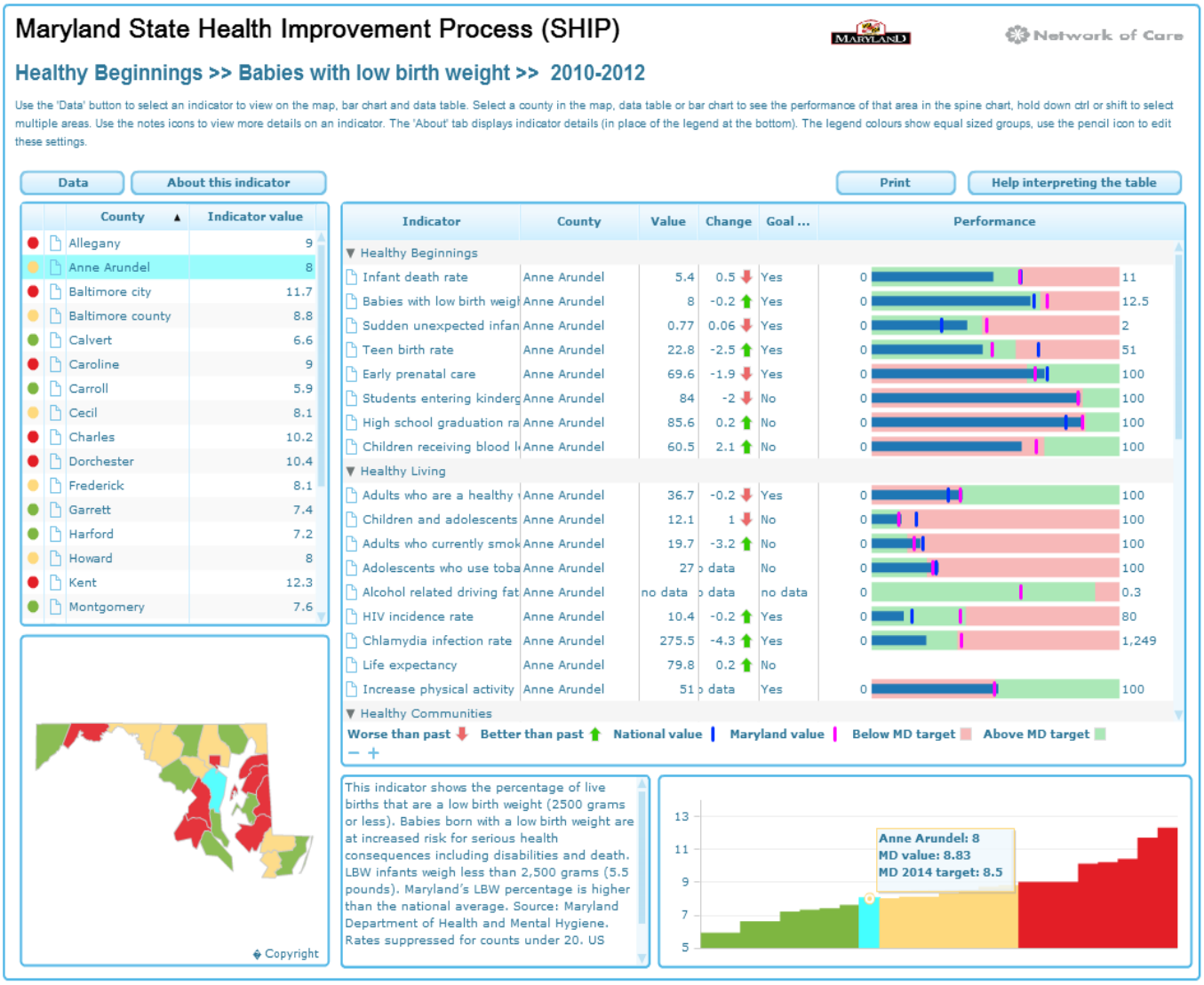
NEW SHIP DASHBOARD: NETWORK OF CARE

While data was provided to LHICs in the first year of SHIP, DHMH determined that user-friendly, graphically-based public dashboard was needed to track progress and provide a data infrastructure available to LHICs for use in their planning efforts. In early 2013, DHMH began collaborating with Trilogy Systems Corporation to pilot its Network of Care data platform. Network of Care is a powerful vehicle improving community health because of its ability to integrate SHIP indicators with other useful information in a user-friendly portal. This new web platform hosts both the state-level SHIP site (Figure 2) and a site for each LHIC, which local health officers can manage and customize to meet the needs of their communities and support their coalition efforts.

A few of the key features that the Network of Care sites have enabled include: statewide, interactive, geo-mapping of all SHIP health indicators by county (see Figure 3); best practices from around the country that have been shown to improve outcomes on various health measures; and a library section that contains everything from research articles to nationwide support groups and interactive tools.

Figure 2: SHIP Network of Care Home Page

Figure 3: SHIP Interactive Dashboard



CHANGES TO SHIP MEASURES AND REPORTING

Changes in the SHIP framework were prompted by the expansion of data capabilities through the SHIP's partnership with Network of Care during Year Two. This increased capacity prompted a review of the Year One SHIP measures and the need to align them with the goals and target areas of the LHICs. In order to provide the most effective data and resources to the LHICs, some measures have been added, removed, or changed from Year Two to Year Three of the SHIP. The updated vision area categories include healthy beginnings, healthy living, healthy communities, access to health care, and quality preventive care.

The following measures were **added** to the SHIP in 2013:

1. **Blood lead screening**—Screening for high blood lead levels is important in young children. This SHIP measure shows the percentage of children ages 12 to 23 months who are enrolled in Medicaid and received at least one blood lead screening.
2. **Physical activity**—Adequate physical activity among adults is a Healthy People 2020 goal. Adults who performed at least 150 minutes of moderate or vigorous physical activity per week were considered physically active. These data are obtained from the Maryland Behavioral Risk Factor Surveillance System (BRFSS).
3. **Affordable housing**—Housing quality has been associated with a number of health outcomes. This measure demonstrates the percentage of houses sold that are affordable, based on an average teacher's salary. These data are obtained from the Maryland State Department of Education (MSDE) and Maryland Department of Planning (MDP).
4. **Mental health emergency department (ED) visits**—SHIP previously included behavioral health ED visit rates from the Health Services Cost Review Commission (HSCRC). This measure has been split into two new measures to provide additional information. The mental health ED visit measure displays the rate of ED visits where the primary or secondary diagnosis was for adjustment disorders, anxiety disorders, attention deficit, conduct or disruptive behavior disorders, disorders usually diagnosed in infancy, childhood, or adolescence, impulse control disorders (not classified elsewhere), mood disorders, personality disorders, schizophrenia and other psychotic disorders, suicide and intentional self-inflicted injury, and miscellaneous mental disorders.
5. **Addictions-related ED visits**—This measure displays the rate of ED visits where alcohol-related disorders or substance-related disorders were the primary or secondary diagnosis. These data were obtained from the HSCRC.

The following measures were **removed** from the SHIP in 2013:

1. **Access to Healthy Food** – The access to healthy food measure from USDA is updated every four years, and therefore does not satisfy the SHIP's annual updates requirement.
2. **Tuberculosis Treatment Completion** – The tuberculosis treatment completion measure was not available at the county level, and therefore was removed from the SHIP.

SHIP target goals for improvement expired in 2014. OPHI is currently in the process of reviewing the current measures and establishing new target goals for 2017. This process has involved continuous stakeholder input and extensive data review. The new measures and target goals will be released in early 2015. In addition, a group of local health officers is currently working with DHMH to better align LHIC SHIP community reporting requirements with duplicative local health department program reporting requirements in order to reduce the reporting burden and streamline efforts.

CAPACITY AND SUSTAINABILITY IN A TRANSFORMING HEALTH CARE DELIVERY SYSTEM

Maryland's health care delivery system is in a state of rapid transformation. In the new All-Payer Hospital Model,[1] Maryland hospitals are moving to global budgets, which establishes a strong financial incentive to reduce utilization and improve population health. Hospitals are investing new resources into care management and prevention activities in order to meet their financial tests under the new model. Moreover, delivery models such as Accountable Care Organizations (ACOs) and Patient-Centered Medical Homes (PCMHs) are already widespread, and their proliferation will continue as other parts of the delivery system transform to align with the All-Payer Model. This additional transformation comes ahead of Phase 2 of the All-Payer Hospital Model, which establishes a total cost of care test for all health care delivery settings – not just acute care. With these changes, for the first time, the basic financial incentives in health care delivery are aligned with SHIP and population health improvement.

In addition, Maryland developed a State Health Innovation Plan[2] that outlines additional models to complement the All-Payer Hospital Model. The plan includes a concept for Community Integrated Medical Homes (CIMH), a modification of the PCMH model that would integrate primary care with evidence-based, intensive, non-clinical interventions for individuals with significant health needs and high costs, such as individuals with multiple chronic conditions. These so-called "super-utilizers" would receive assessments, intensive education and self-management training, and other interventions in home and community-based settings. In addition, the State Health Innovation Plan calls for establishing a Medicaid ACO. The plan was developed as part of a State Innovation Models design grant from the Center for Medicaid and Medicaid Innovation (CMMI). Although no funds have been awarded from CMMI to implement the model to date, local jurisdictions are implementing pilots of the CIMH model and a process is underway to more fully develop the Medicaid ACO.

It is the goal of DHMH to move away from grant-based funding for LHICs to a dedicated funding stream that is part of the transforming health care financing system. Initial funding for LHIC establishment and development came primarily through a partnership with the Maryland Hospital Association (MHA). Funding from MHA has tapered off in recent years and LHIC funding is now predominantly supported through state funding, including grants from the Community Health Resources Commission (CHRC). DHMH is currently working with CHRC and HSCRC on funding opportunities that would give LHICs enhanced capacity to deploy community interventions and integrate local services in order to more rapidly meet SHIP targets while also assisting hospitals in meeting their financial tests. In addition, DHMH will be working with MHA and HSCRC to strongly encourage the use of hospital savings and community benefits dollars to fund local interventions under LHIC action plans. Movement in this direction is occurring as an increasing number of hospitals are aligning their community health needs assessments with SHIP and LHIC plans.

In addition to funding, long term sustainability for SHIP will be bolstered by national public health accreditation at the state and local level. The creation, implementation and ongoing support of a health improvement plan is a pre-requisite for the five year accreditation certificate from the Public Health Accreditation Board (PHAB).

[1] http://www.hscrc.state.md.us/
[2] http://hsia.dhmh.maryland.gov/SitePages/sim.aspx

Report Cards

Each year, a report card is created to communicate how well Maryland is doing in reaching SHIP target goals. The report card is posted on the SHIP website and distributed through social media platforms. The report cards for 2013 and 2014 are presented below. The 2013 card shows progress toward meeting the original 2014 target goals and the 2014 report card shows whether or not those targets were met.

2013 Report Card

Category	Measure	2013 Results
Healthy Beginnings	Reduce infant deaths	
	Reduce the percent of low birth weight births	
	Reduce sudden unexpected infant deaths (SUIDs)	
	Reduce the teen birth rate	
	Increase the % of pregnancies starting care in the 1st trimester	
	Increase the proportion of children who receive blood lead screenings*	
	Increase the % entering kindergarten ready to learn	
	Increase the percent of students who graduate high school	
Healthy Living	Increase the % of adults who are physically active	
	Increase the % of adults who are at a healthy weight	
	Reduce the % of children who are considered obese	
	Reduce the % of adults who are current smokers	
	Reduce the % of youths using any kind of tobacco product	
	Decrease the rate of alcohol-impaired driving fatalities	
	Reduce new HIV infections among adults and adolescents	
	Reduce Chlamydia trachomatis infections	
Healthy Communities	Reduce child maltreatment	
	Reduce the suicide rate	
	Reduce domestic violence	
	Reduce the % of young children with high blood lead levels	
	Decrease fall-related deaths	
	Reduce pedestrian injuries on public roads	
	Reduce Salmonella infections transmitted through food	
	Reduce the number of unhealthy air days	
	Increase the number of affordable housing options*	
Access to Health Care	Increase the proportion of persons with health insurance	
	Increase the % of adolescents receiving an annual wellness checkup	
	Increase the % of children receiving dental care	
	Reduce % of individuals unable to afford to see a doctor	
Quality Preventive Care	Reduce deaths from heart disease	
	Reduce the overall cancer death rate	
	Reduce diabetes-related emergency department visits	
	Reduce hypertension-related emergency department visits	
	Reduce drug-induced deaths	
	Reduce emergency department visits related to mental health conditions*	

Reduce emergency department visits for addictions-related conditions*	
Reduce the number of hospitalizations related to Alzheimer's disease	
Increase the % of children with recommended vaccinations	
Increase the % vaccinated annually for seasonal influenza	
Reduce hospital emergency department visits for asthma	

Note: * Indicates New Measures Added in 2013

	Measure on track to meet Maryland 2014 target.
	Measure is moving toward the Maryland 2014 target.
	Measure is not moving toward the Maryland 2014 target.
	Data for update is pending

2014 Report Card

The 2014 report card shows that targets were met for 16 out of the 41 SHIP measures met the 2014 target goal. Notable successes include infant mortality, reducing obesity, youth tobacco use, drunk driving, HIV infections, and mortality from cancer and heart disease. Moreover, statistically significant improvements were seen in an additional 12 measures, including low birth weight, adult smoking, flu vaccination, child blood lead levels, and overall life expectancy. However, Maryland was unsuccessful in a number of areas, including emergency department visits for a number of conditions, childhood vaccinations, child maltreatment, and injuries. OPHI will continue tracking these measures and working with LHICs to identify promising strategies to help meet newly established targets for 2017.

Measures for which the 2014 target was met:

1. Reduce infant deaths
2. Reduce the teen birth rate
3. Increase the % of pregnancies starting care in the 1st trimester
4. Increase the % of adults who are at a healthy weight
5. Reduce the % of children who are considered obese
6. Reduce the % of youths using any kind of tobacco product
7. Decrease the rate of alcohol-impaired driving fatalities
8. Reduce new HIV infections among adults and adolescents
9. Reduce domestic violence
10. Reduce the number of unhealthy air days
11. Increase the number of affordable housing options
12. Increase the % of adolescents receiving an annual wellness checkup
13. Increase the % of children receiving dental care
14. Reduce deaths from heart disease
15. Reduce the overall cancer death rate
16. Reduce the number of hospitalizations related to Alzheimer's disease

Category	Measure	2014 Results
Healthy Beginnings	1. Reduce infant deaths	
	2. Reduce the percent of low birth weight births	
	3. Reduce sudden unexpected infant deaths (SUIDs)	
	4. Reduce the teen birth rate	
	5. Increase the % of pregnancies starting care in the 1st trimester	
	6. Increase the proportion of children who receive blood lead screenings*	
	7. Increase the % entering kindergarten ready to learn	
	8. Increase the percent of students who graduate high school	
Healthy Living	9. Increase the % of adults who are physically active	
	10. Increase the % of adults who are at a healthy weight	
	11. Reduce the % of children who are considered obese	
	12. Reduce the % of adults who are current smokers	
	13. Reduce the % of youths using any kind of tobacco product	
	14. Decrease the rate of alcohol-impaired driving fatalities	
	15. Reduce new HIV infections among adults and adolescents	
	16. Reduce Chlamydia trachomatis infections	
	17. Increase life expectancy	
Healthy Communities	18. Reduce child maltreatment	
	19. Reduce the suicide rate	
	20. Reduce domestic violence	
	21. Reduce the % of young children with high blood lead levels	
	22. Decrease fall-related deaths	
	23. Reduce pedestrian injuries on public roads	
	24. Reduce Salmonella infections transmitted through food	
	25. Reduce the number of unhealthy air days	
	26. Increase the number of affordable housing options*	
Access to Health Care	27. Increase the proportion of persons with health insurance	
	28. Increase the % of adolescents receiving an annual wellness checkup	
	29. Increase the % of children receiving dental care	
	30. Reduce % of individuals unable to afford to see a doctor	
Quality Preventive Care	31. Reduce deaths from heart disease	
	32. Reduce the overall cancer death rate	
	33. Reduce diabetes-related emergency department visits	
	34. Reduce hypertension-related emergency department visits	
	35. Reduce drug-induced deaths	
	36. Reduce emergency department visits related to mental health conditions*	
	37. Reduce emergency department visits for addictions-related conditions*	
	38. Reduce the number of hospitalizations related to Alzheimer's disease	
	39. Increase the % of children with recommended vaccinations	
	40. Increase the % vaccinated annually for seasonal influenza	
	41. Reduce hospital emergency department visits for asthma	

	Measure met the Maryland 2014 target.
	Measure showed statistically significant improvement but did not meet Maryland 2014 target.
	Measure did not show statistically significant improvement.

PROGRESS ON INDIVIDUAL SHIP MEASURES

This section assesses progress toward meeting each individual SHIP measure. The information includes an indicator of whether or not the 2014 goal was met and trends in recent years, as well as data on racial/ethnic disparities where available. Target goals highlighted in green indicate the target was met, while yellow indicates that the target was not met but statistically significant progress toward the target was achieved. Red indicates no significant progress. Some measures also include data by county and a spotlight on promising strategies being implemented by LHICs to address that particular health need. The data used for these measures is often subject to a time lag; the measures reflect the most currently available data. The measures are grouped by category:

HEALTHY BEGINNINGS

HEALTHY LIVING

HEALTHY COMMUNITIES

ACCESS TO HEALTH CARE

QUALITY PREVENTIVE CARE

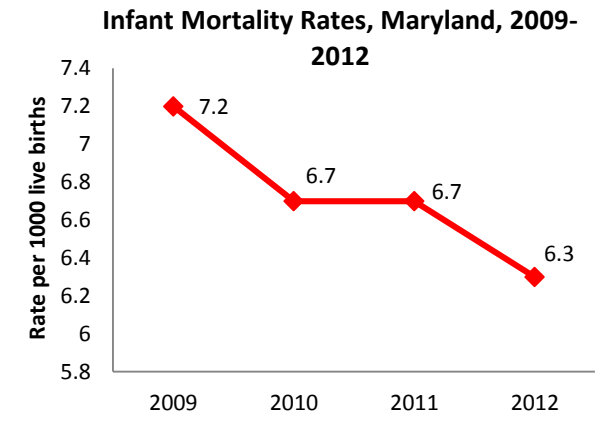
HEALTHY BEGINNINGS

Infant Mortality Rate

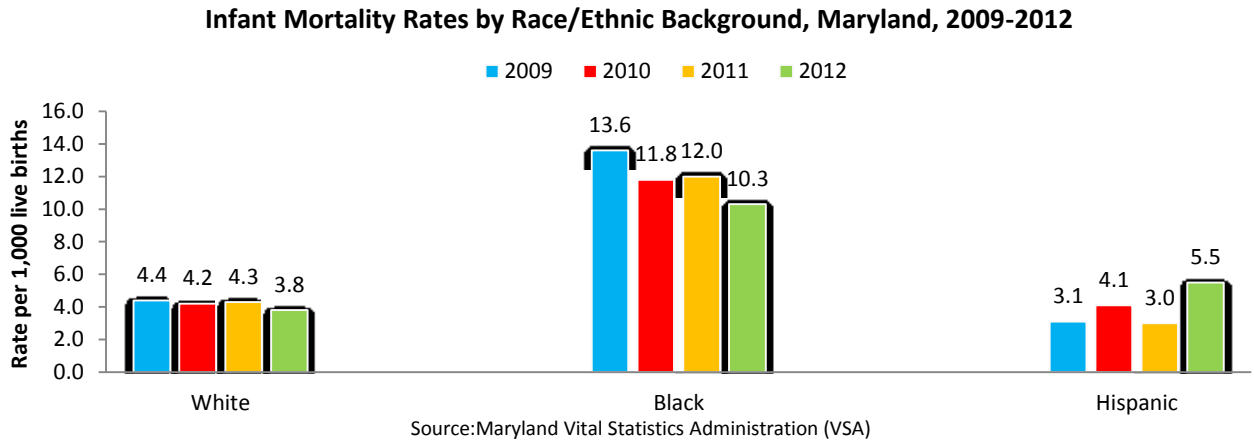
This indicator shows the infant mortality rate per 1,000 live births. Infant mortality has long been considered one of the most sensitive indicators of overall population health. Maryland's rates have been higher than the national average in recent years, but the gap has been closing.

Goal: 6.6

Trends: Infant mortality rates in Maryland have declined considerably during the past several years to surpass the target goal. The infant mortality rate was 6.3 per 1,000 live births in 2012, an historic low for the state and a 12.5% decline from the 2009 rate of 7.2. The rate was 4.1 among whites, 10.3 among blacks and 5.5 among Hispanics. The infant mortality rate in white infants has remained stable since 2009. In contrast, the rate in black infants has fallen in recent years, especially since 2009 (13.6) reaching a rate of 10.3 per 1000 live births in 2012 (24.3% decline). The rate among Hispanic infants showed a 32.3% increase from the 2009 rate of 3.1.



Source: Maryland Vital Statistics Administration (VSA)



Source:Maryland Vital Statistics Administration (VSA)

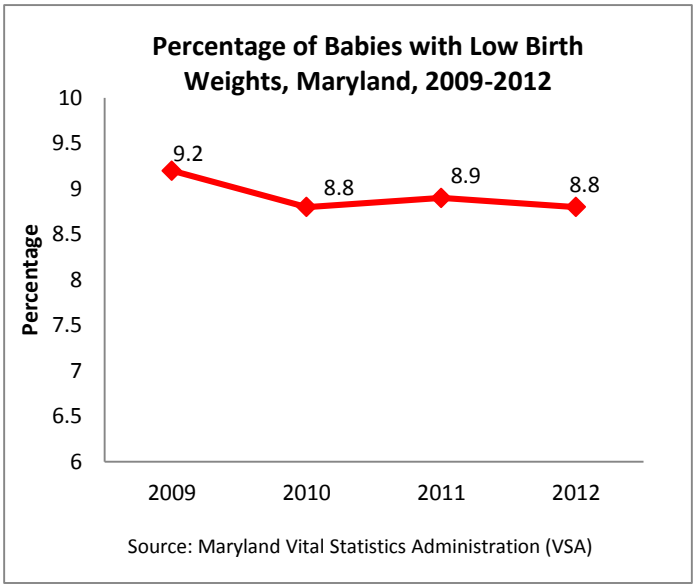
PROMISING LOCAL STRATEGY

The **B'more for Healthy Babies (BHB)** program works to decrease premature birth, low birth weight birth, and unsafe sleep in Baltimore City. The program aims to reduce infant mortality by emphasizing policy change, service improvements, community mobilization, and behavior change. BHB provides home visiting for mothers with high risk pregnancies, as well as family planning services and educational materials on safe sleeping. They also work closely with substance using families to prevent substance exposed pregnancies. Partners in the program also provide free cribs to families in need.

Babies with Low Birth Weight

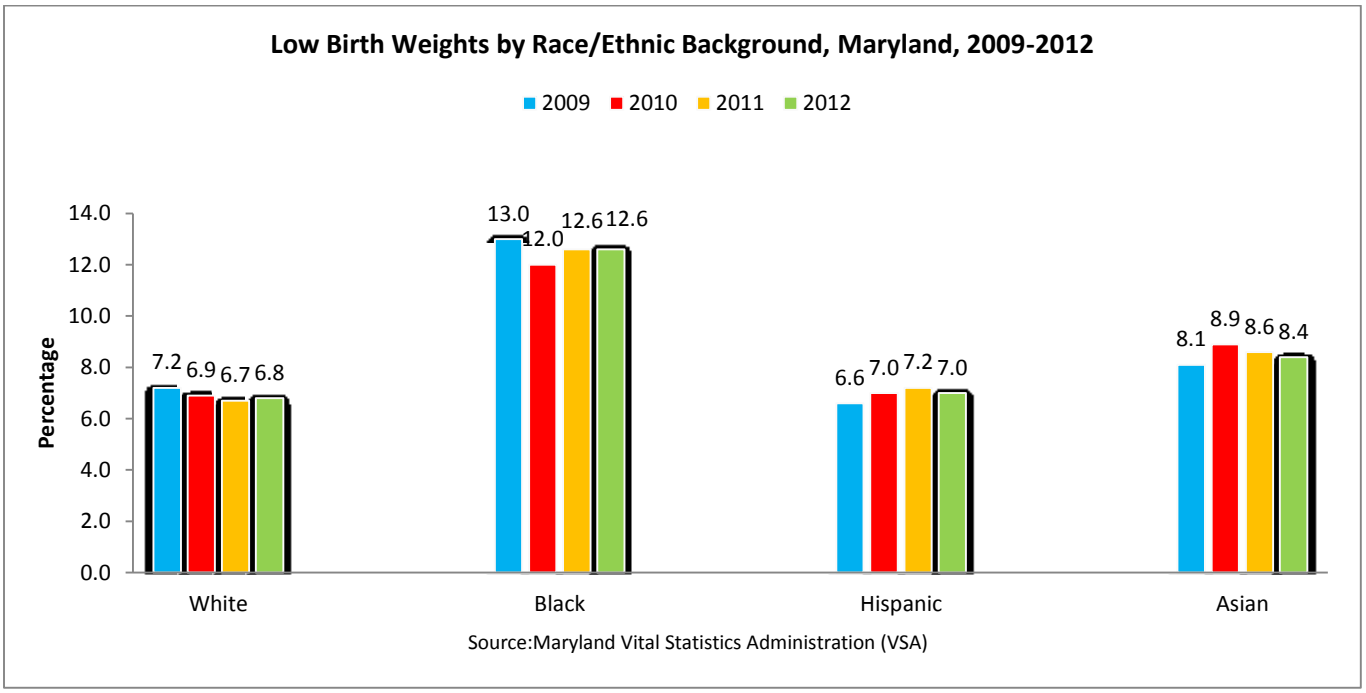
This indicator shows the percentage of live births that are a low birth weight (2,500 grams or less). A baby's weight at birth is a strong indicator of maternal and newborn health and nutrition. Babies born with a low birth weight are at increased risk for serious health consequences, including neurological and developmental disabilities, compared to babies with a normal birth weight.

Goal: 8.5



Trends: The rate of low birth weights in Maryland decreased from 9.2% in 2009 to 8.8% in 2012, but did not fall far enough to meet the target goal. The Maryland's rate is higher than the national average of 8.0% and does not meet the Healthy People 2020 goal of 7.8%. At the county level, the rates in Baltimore City, Dorchester, Charles, and Prince George's Counties have been higher than other counties.

Black infants have a substantially higher incidence of low birth weights than other infants. Between 2009 and 2012, the average rate among black infants was 12.6%, whereas the average rate among white infants was 6.9%.



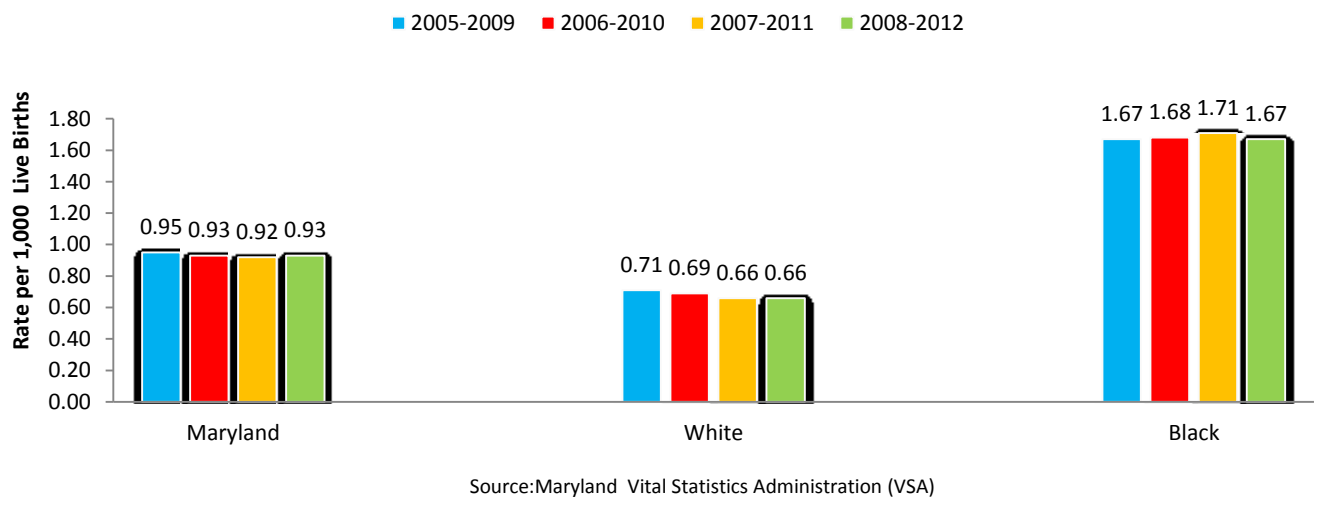
Sudden Unexpected Infant Death Rate

This indicator shows the rate of sudden unexpected infant deaths (SUIDs) per 1,000 live births. SUIDs are defined as deaths in infants less than one year of age that occur suddenly and unexpectedly and whose cause of death are not immediately obvious prior to investigation. The three most frequently reported causes are SIDS, cause unknown, and accidental suffocation and strangulation in bed.

Goal: 0.9

Trends: The rates of SUIDs in Maryland has slightly deceased since the baseline year. The average rate was 0.95 between 2005 and 2009, and slightly declined to 0.93 between 2008 and 2012. However, the rate is still higher than the target goal of 0.9. At the county level, the average rates of SUIDs were highest in Baltimore City and Prince George's County between 2008 and 2012, where the rates were 1.90 and 1.31, respectively. The rates have been significantly higher in black infants compared to white infants. Between 2008 and 2012, the average rate among black infants was 1.67, whereas the average rate among white infants was 0.66.

Sudden Unexpected Infant Death Rates by Race/Ethnic Background, Maryland, 2009-2012



Source:Maryland Vital Statistics Administration (VSA)

PROMISING LOCAL STRATEGY

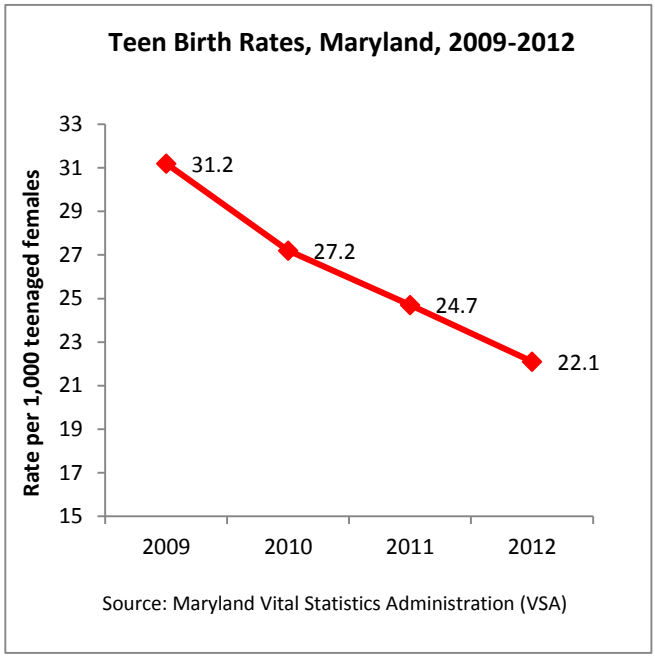
The **Frederick County Health Care Coalition** focused on promoting best practices regarding safe sleeping to reduce SUIDs. Pack-n-Play cribs were purchased and distributed free of charge to families who did not have or could not afford a crib for their newborns. In addition, safe sleep educational materials were posted in locations where parents with newborns are likely to view the materials. The program is a community collaborative effort led by the Frederick County Health Department's Maternal and Child Health program.

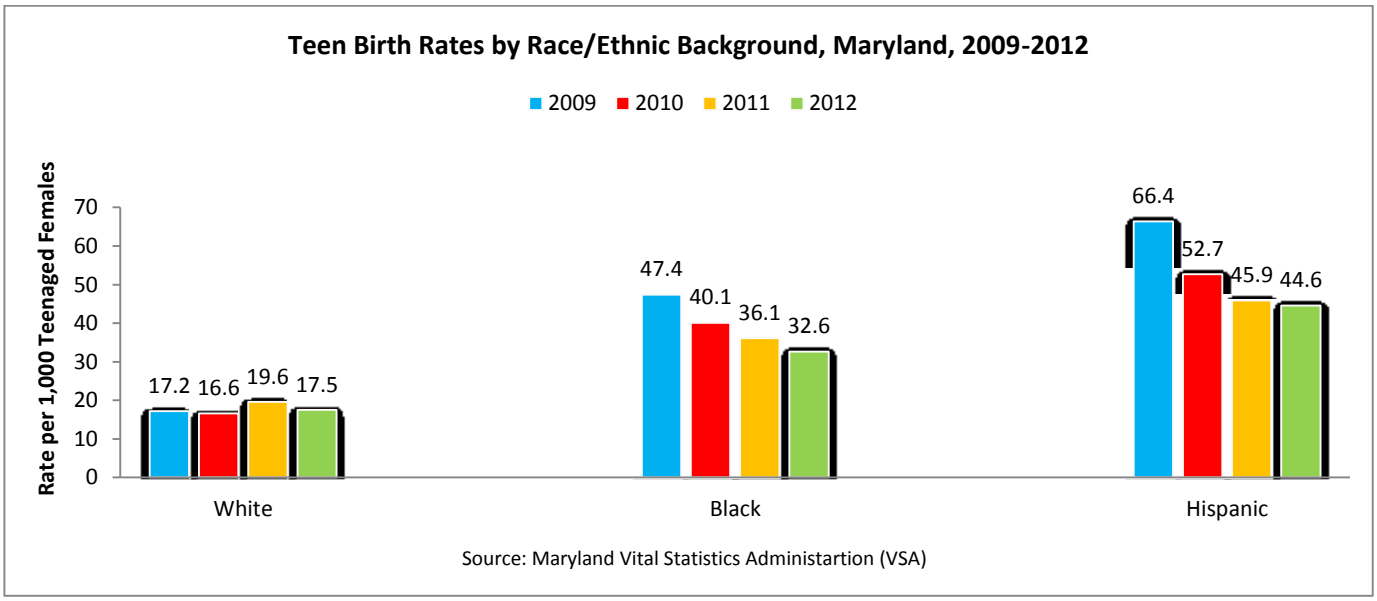
Teen Birth Rate

This indicator shows the rate of births to teens ages 15-19 years (per 1,000 population). Teen pregnancy is linked to a host of social problems such as poverty, lack of overall child well-being, out-of-wedlock births, lack of responsible fatherhood, health issues, school failure, child abuse and neglect, and at-risk behaviors. In addition, there are health risks for children born to teenage mothers.

Goal: 29.6

Trends: The rate of teen births in Maryland significantly decreased from 31.2% in 2009 to 22.1% in 2012 (a 29.2% decline), easily surpassing the target goal. There have also been significantly declines in the average teen birth rates in all counties. Despite the significant declines, teen birth rates differ substantially by counties and race/ethnic backgrounds. The average teen birth rates in 9 counties (Allegany, Baltimore City, Caroline, Cecil, Dorchester, Garrett, Prince George's, Washington, and Wicomico) were statistically significantly higher than the state average between 2010 and 2012. During this time period, Baltimore City and Dorchester County had the highest rates at 50.5 and 48.8 per 1,000 teenaged females, respectively. Hispanic teenaged females have the highest birth rate compared to other races. However, the rate has declined almost continuously over the past several years, with the rate among Hispanics decreasing by 32.8% between 2009 and 2012.



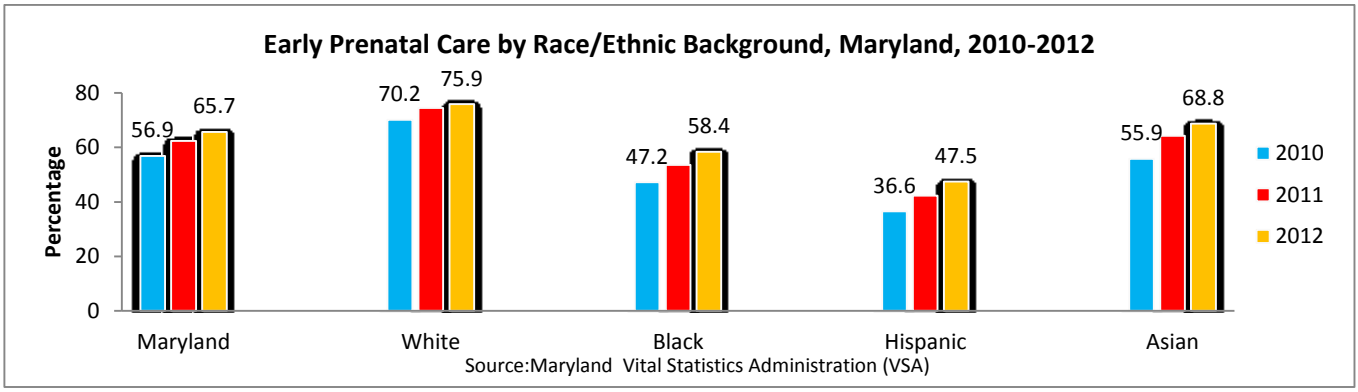


Early Prenatal Care

This indicator shows the percentage of pregnant women who receive prenatal care beginning in the first trimester. Inadequate prenatal care services have been linked to higher rates of infant mortality, low birth weight, and pre-term deliveries.

Goal: 62.6

Trends: In 2012, the percentage of women who receive prenatal care beginning in the first trimester was 65.7%, a 5.3% increase from the previous year that surpassed the target goal of 62.6%. The percentage varies widely across counties and among race/ethnic backgrounds. Between 2011 and 2012, seven counties (Baltimore City, Calvert, Charles, Frederick, Montgomery, Prince George's, and Washington) showed a significant increase in the rates of pregnant women who receive care in the first trimester, while though the rates in Baltimore City, Montgomery County, and Prince George's County remained below the state average. From 2011 through 2012, the rate increased 1.8% among whites, 7.0% among Asians, 9.0% among blacks, and 29.8% among Hispanics. Despite the increase, the rate among Hispanics is significantly below the state average.

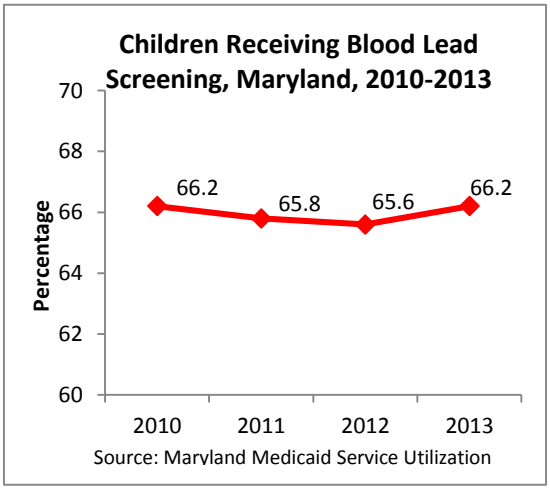


Children Receiving Blood Lead Screening

Lead poisoning and lead exposure remain significant public health problems in Maryland. Because symptoms may not be visible until the blood lead levels of 70 µg/dL are reached, it is important to screen for elevated blood lead levels among toddlers. SHIP indicator reflects the percentage of children (aged 12-35 months) enrolled in Medicaid (90+ days) who had received a blood lead screening. For more on childhood lead exposure, see page 29.

Goal: 69.5

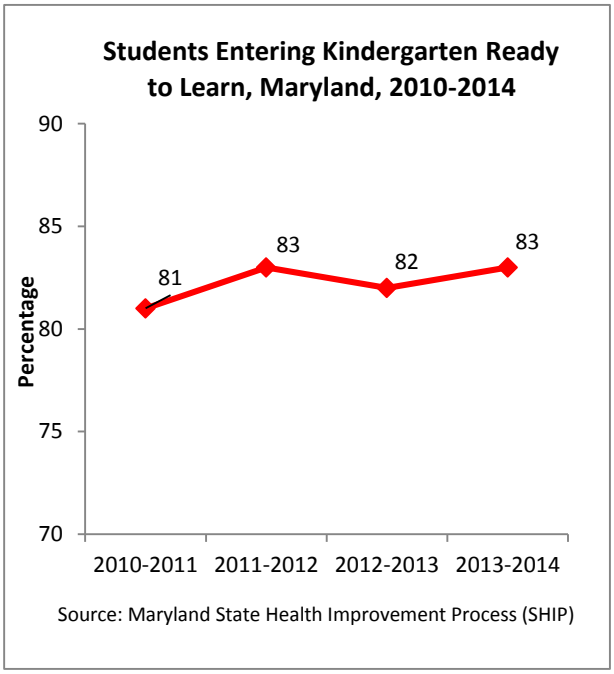
Trends: The percentage of children receiving blood lead screening has been relative stable since 2010. In 2013, 66.2 % of children aged 12-35 months in Maryland were tested for blood lead levels. This was an increase of 0.9% when compared to 65.6% of children tested in 2021, but matches the baseline in 2010. The highest testing rates for children 12-35 months of age were found in Allegany County (82.2%), Somerset County (82.1%), Caroline County (78.5%), Talbot County (76.9%), and Baltimore City (75.1%). Baltimore City, Somerset, Worcester, and Allegany Counties are identified in Maryland's Targeting Plan as being 100% "at-risk".



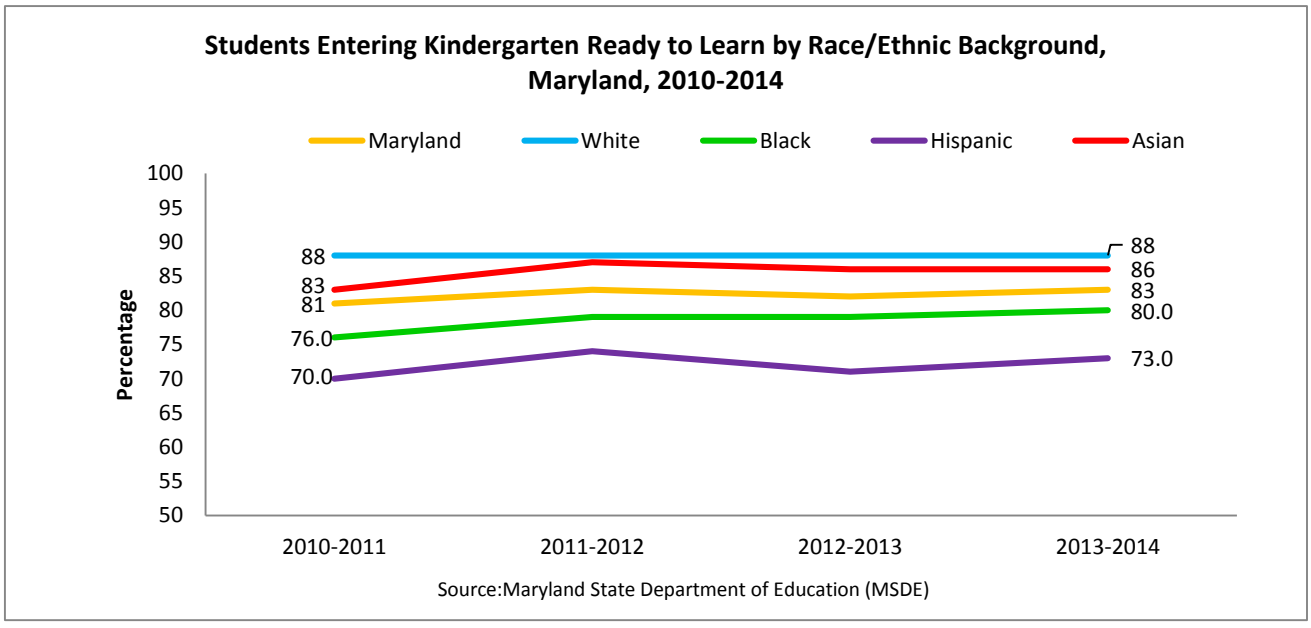
Students Entering Kindergarten Ready to Learn

This indicator shows the percentage of students who enter Kindergarten ready to learn. Readiness to learn in the first year of school is strongly linked to later school success, which is predictive of adult health. Full readiness to learn is defined as consistently demonstrating skills, behaviors, and abilities which are needed to successfully meet Kindergarten expectations. The seven domains assessed are (1) personal and social Development, 2) Language and literacy, 3) Mathematical thinking, 4) Scientific thinking, 5) Social studies, 6) The arts and 7) Physical development.

Goal: 85.0



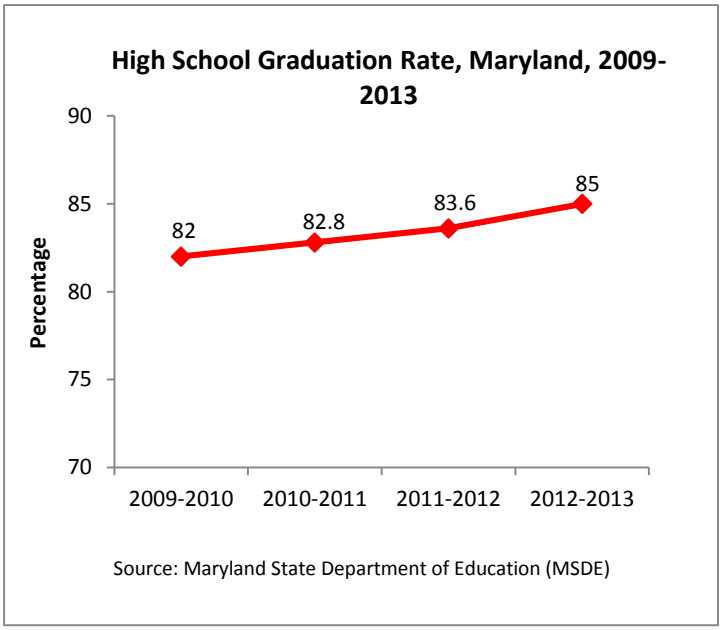
Trends: For the state of Maryland, 83% of entering kindergarteners are fully ready in 2013-2014, up from 49% in 2001-2002, a 69% improvement in readiness over the past 12 years. Between 2013 and 2014, the average rate of kindergarteners ready to learn was 83%, a 2% increase from the average rate of 81% between 2010 and 2011. So, it is steadily approaching the Maryland 2014 goal of 85%. The percentages of entering kindergarteners ready to learn vary by race and ethnic backgrounds. The percentages among white and Asian children are higher than the state average. The percentage among Hispanics is the lowest; it was a 10% lower than the state average between 2013 and 2014. At the county level, most counties have shown a steady increase in the percentages with the exception of Washington, Talbot, Kent, Dorchester, Calvert, Garrett, and Howard, where the percentages have slightly declined.



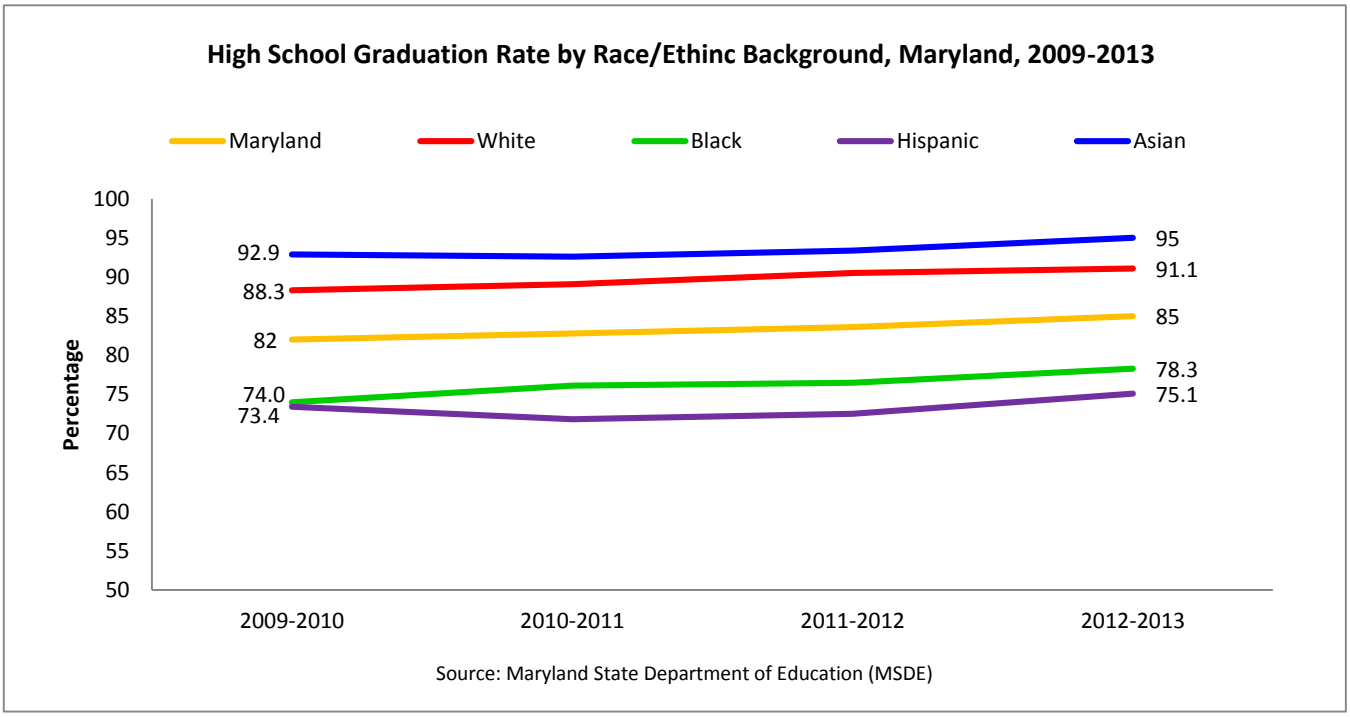
High School Graduation Rate

This indicator shows the percentage of students who graduate high school in four years. Completion of high school is one of the strongest predictors of health in later life. People who graduate from high school are more likely to have better health outcomes, regularly visit doctors, and live longer than those without high school diplomas.

Goal: 86.1



Trends: High school graduation rates in Maryland have increased consistently over the past years from 82.0% in the years 2009-2010 to 85.0% in the years 2012-2013. This 3.7% increase was statistically significant. While the rate is currently higher than the Healthy People 2020's goal of 82.4%, it is still below Maryland's target of 86.1%. At the county level, the rates have increased in all counties with the exception of Prince George's, and Somerset. The rates of high school graduation vary by race and ethnic backgrounds. The rates among Asian and white students have been significantly higher than black and Hispanic students. Furthermore, the rates among blacks and Hispanics are lower than the national average and the Healthy People 2020's goal.



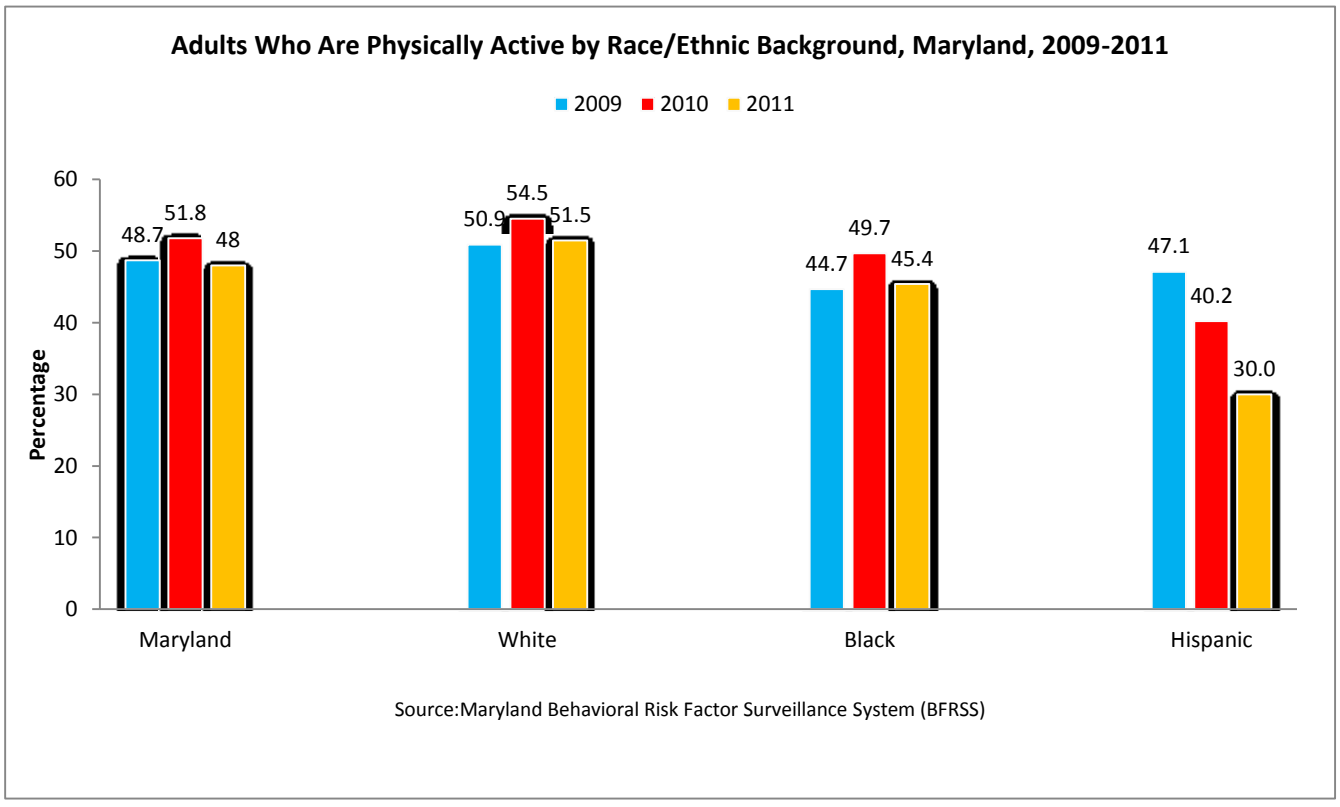
HEALTHY LIVING

Physical Activity in Adults

This indicator shows the number of persons who reported at least 150 minutes of moderate physical activity or at least 75 minutes of vigorous physical activity per week. Physical activity is important to prevent heart disease and stroke, two of the important causes of death in United States. In order to improve overall cardiovascular health, The American Heart Association suggests at least 150 minutes per week of moderate exercise or 75 minutes per week of vigorous exercise.

Goal: 49.8

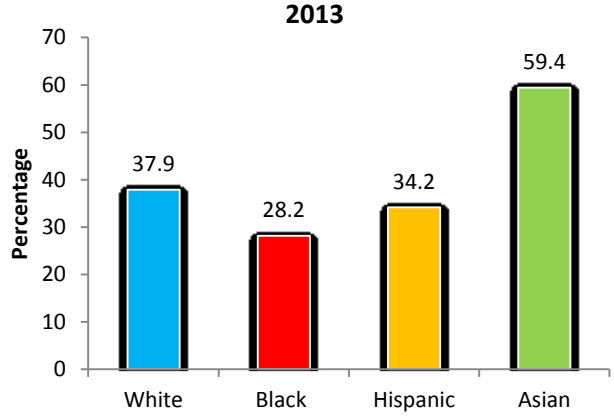
Trends: The percentage of adults who are physically active increased from 48.7% in 2011 to 51.8% in 2012, but fell to 48.0% in 2013. The significant decline in the overall percentage between 2012 and 2013 was mainly the result of a 30% decline in the rate among Hispanics. Despite the single year decrease, the overall percentage of adults who participate in vigorous physical activity is higher than the Healthy People 2020's goal of 47.9%. However, the Maryland goal of 49.8% has not been met. At the county level, the highest percentages were reported in Talbot (54.2%), St. Mary's (53.5%), Montgomery (53.3%), Frederick (53.2%), Worcester (53.1%), Howard (53%), and Charles (52.3%), where the percentages were statistically significantly higher than the state average. Caroline (36%), Somerset (37%), and Dorchester (39.9%) had the lowest percentages, which were significantly lower than the state average.



Healthy Weight in Adults

This indicator shows the percentage of adults who are at a healthy weight. Forty percent of heart disease, stroke, and diabetes can be prevented through maintaining a healthy weight. Healthy weight can aid in the control of these conditions if they develop.

Goal: 35.7



Source: Maryland Behavioral Risk Factor Surveillance System (BRFSS)

Trends: Between 2011 and 2013, the percentage of adults with a healthy weight remained stable. In 2013, Maryland had 35.9% of adults with a healthy weight, which exceeded the Maryland target and the Healthy People 2020 goal of 33.9%. At the county level, 10 counties have met the Healthy People 2020 goal (Anne Arundel, Baltimore City, Carroll, Frederick, Garrett, Harford, Howard, Montgomery, Queen Anne's, and Talbot). During this time period, Harford County had a significant increase in the percentage of adults with a healthy weight, where the percentage increased by 10.4%. From 2011 through 2013, Asians had the highest percentage of adults with a healthy weight, whereas the percentage was lowest among blacks.

PROMISING LOCAL STRATEGIES

Adult and childhood obesity have been top priorities for most LHICs since the inception of SHIP. A number of strategies, including the two below, have shown promise:

The **Mid Shore LHIC's Body & Soul Program**, funded by the Community Health Resources Commission, encourages African-American congregations to take better care of their health by providing education on healthy eating and living, peer counseling, and pastoral encouragement. To date, 16 churches participated and 489 people have been screened by taking health risk assessment, which initiates their involvement in further intervention. This evidence-based program was originally developed by Emory University and has been highlighted by the Centers for Disease Control and Prevention (CDC) as a best practice.

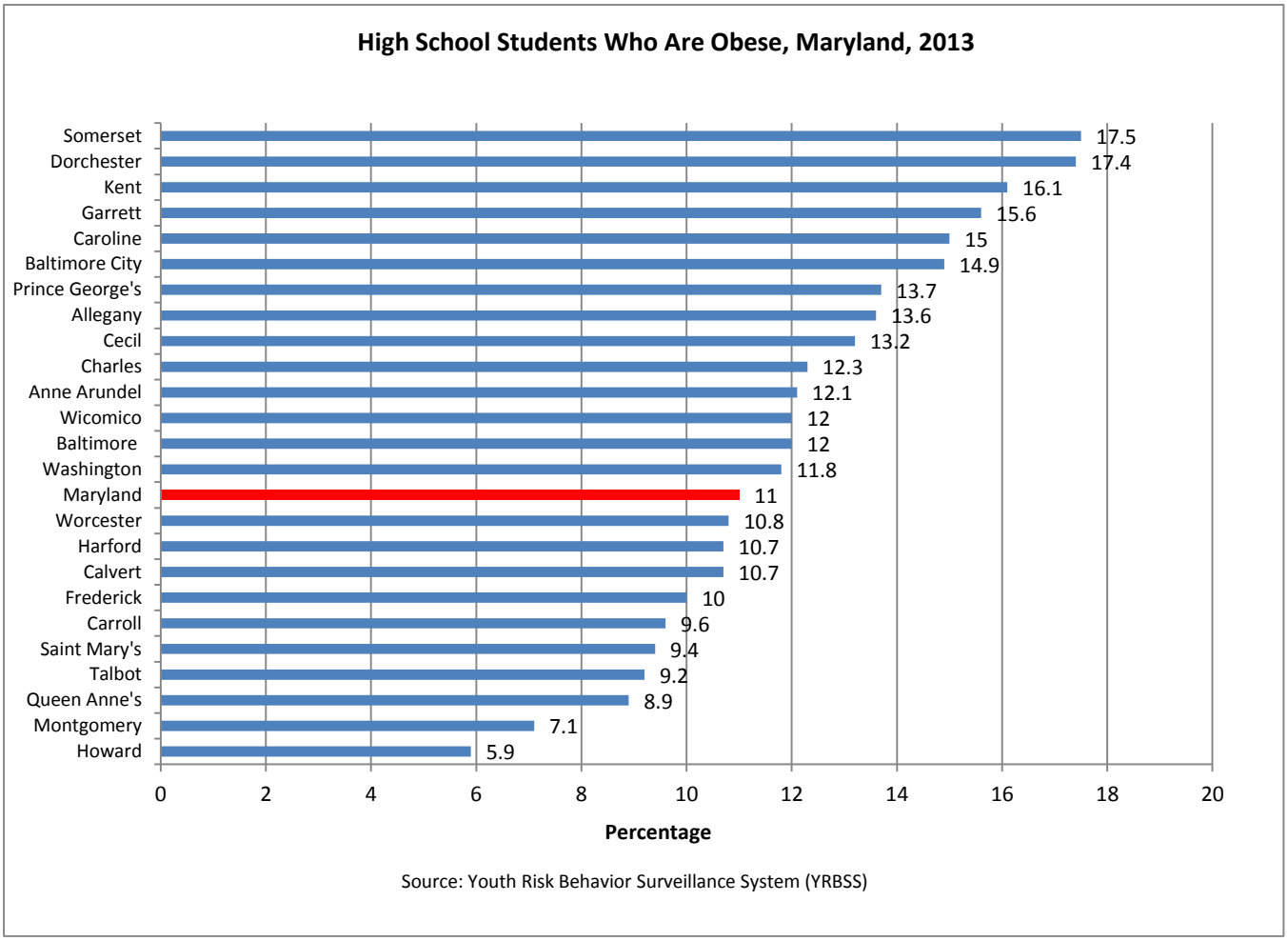
Partnerships for a Healthier Charles County targeted its most recent efforts to reducing obesity and improving overall wellness among children and youth in school, as well as adults. As part of this effort, Partnerships for a Healthier Charles County (PHCC) distributed a pediatric food model kit, launched a school wellness champions campaign, and was influential in the development and implementation of a healthy stores nutrition program. The PHCC, with assistance from the local hospital and health department, continues to engage residents through an obesity prevention and healthy eating campaigns.

Obesity in Children and Adolescents

This indicator shows the percentage of children and adolescents who are obese. In the last 20 years, the percentage of overweight/obese children has more than doubled and has tripled for adolescents. Overweight/obese children are at increased risk of developing life-threatening chronic diseases, such as Type 2 diabetes.

Goal: 11.3

Trends: In 2013, the Maryland Youth Tobacco Survey, which was the main data source for this measure, was combined with the Maryland Youth Risk Behavior Survey (YRBS). The YRBS only includes responses from high school students. Therefore, we are unable to compare the data with the past years, which include both middle school and high school students. For high school students, between 2010 and 2013, the percentage of those who are obese fell from 11.7% to 11.0% (a 6% decline). The percentage of children and adolescents who are obese also differs by race and ethnic backgrounds. The percentages among black and Hispanic children are significantly higher than whites. In 2013, counties in the worst quartile are Somerset (17.5%), Dorchester (17.4%), Kent (16.1%), Garrett (15.6%), Caroline (15%), and Baltimore City (14.9%).



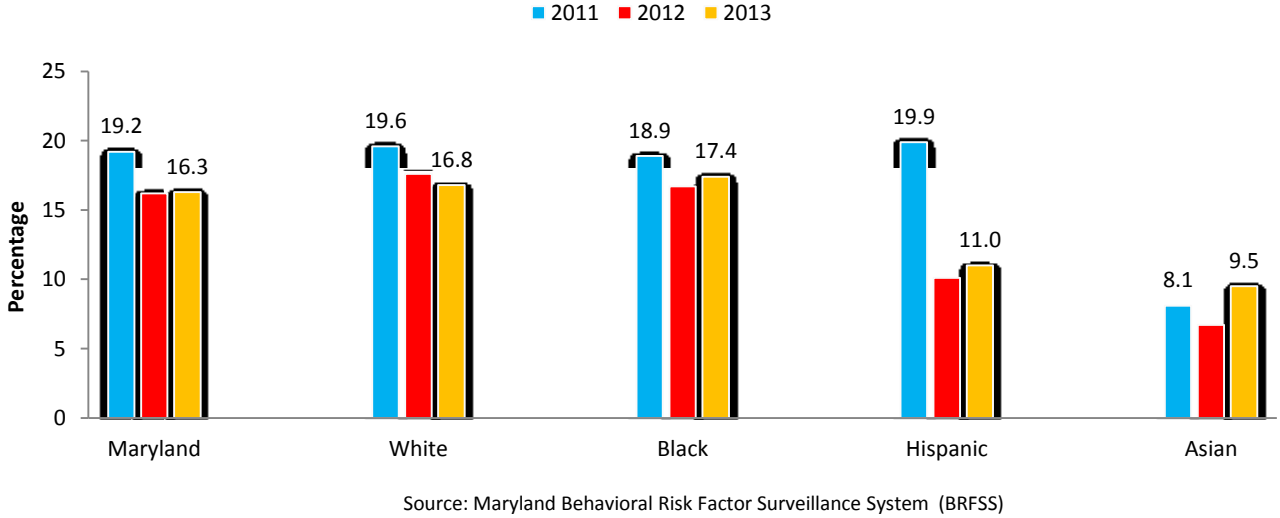
Source: Youth Risk Behavior Surveillance System (YRBSS)

Adults Who Currently Smoke

Cigarette smoking has been identified as the most important source of preventable morbidity (disease and illness) and premature mortality (death) worldwide. This indicator shows the percentage of adults who currently smoke.

Goal: 14.4

Trends: The percentage of adults who currently smoke fell from 19.2% in 2011 to 16.3% in 2013. This 17.8% decline is statistically significant but did not meet the target goal of 14.4%. Cigarette smoking rates have decreased in the past years for all races in the exception of Asians. Furthermore, the rates among Hispanics have substantially declined; the rate fell from 19.9% in 2011 to 11.0% in 2013 (an 80.9% decline). Between 2011 and 2013, the average adult cigarette smoking rates in all counties except Charles, Howard, Montgomery, Prince George's, and Worcester were significantly higher than the state average. The top five counties with the highest adult cigarette smoking in 2011-2013 were Allegany, Baltimore City, Caroline, Kent, and Somerset.



Source: Maryland Behavioral Risk Factor Surveillance System (BRFSS)

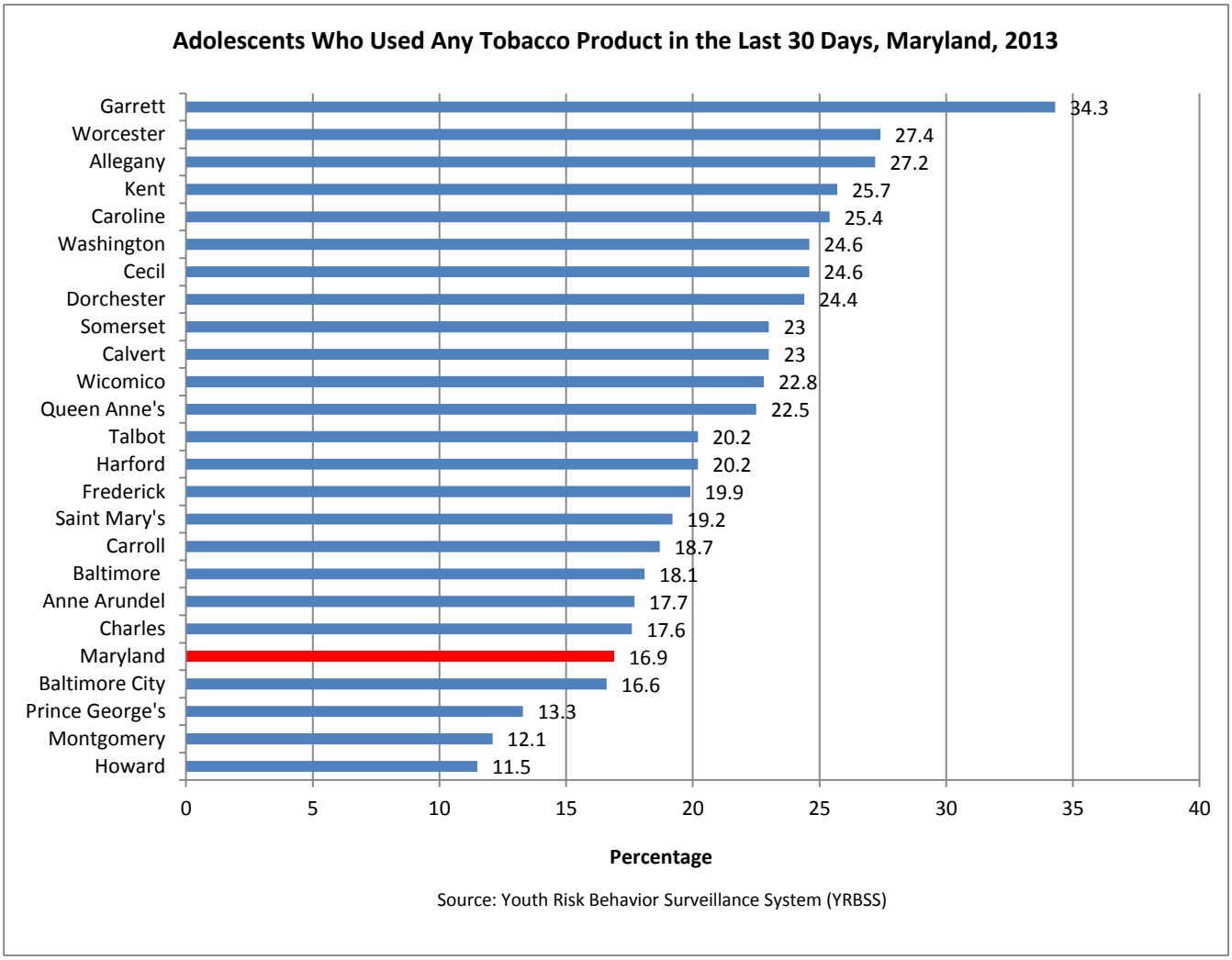
PROMISING LOCAL STRATEGY

Tobacco use has been a priority of the **Carroll County LHIC** since the inception of SHIP. As part of their tobacco strategy, the **Carroll County Health Department** offers community based programs like Stop Using Tobacco for Life, Jump Start to Quitting for tobacco use prevention, cessation and education. Participants in classes receive vouchers for nicotine patches, gum, and lozenges. It offers daytime walk in clinic for tobacco cessation. It works in liaison with University of Maryland Tobacco Law Center to support legislation regarding the sale and placement of cigars. The Cigarette Restitution Fund Program (CRFP) based at the Carroll County Health Department is the lead organization in the county working to reduce tobacco use and exposure to tobacco.

Adolescents using Tobacco Products

This indicator shows the percentage of adolescents who used any tobacco product in the last 30 days. Preventing youth from using tobacco products is critical to improving the health of Marylanders. This highly addictive behavior can lead to costly illnesses and death to users and those exposed to secondhand smoke.

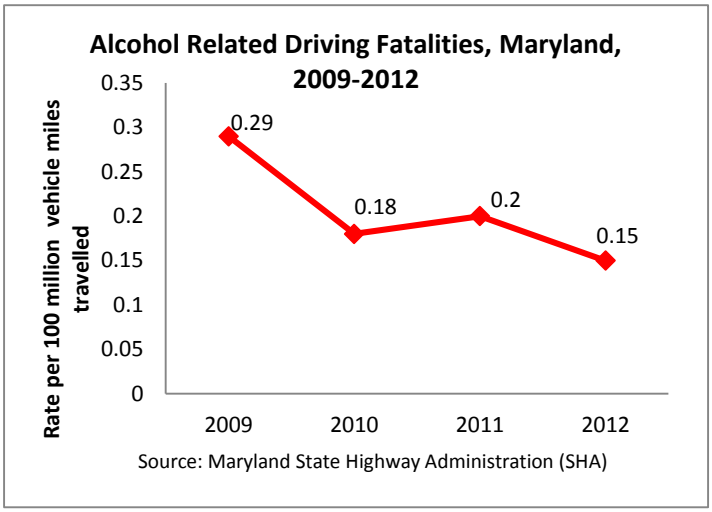
Trends: From 2010 through 2013, the percentage of adolescents who used any tobacco product in the past 30 days declined substantially from 24.8% to 16.9% (a 31.9% decline), easily surpassing the target goal of 22.3%. The percentages significantly declined in all counties except Allegany, where the percentage remained stable. In 2013, counties in the worst quartile are Garrett (34.3%), Worcester (27.4%), Allegany (27.2%), Kent (25.7%), Caroline (25.4%), Cecil (24.6%), and Washington (24.6%).



Alcohol Related Driving Fatalities

This indicator shows the rate of alcohol-impaired driving fatalities per 100 million vehicle miles traveled). Alcohol-impaired driving contributes to a significant number of traffic fatalities in Maryland and creates an unsafe environment for drivers and passengers. Alcohol-impaired driving is often related to substance abuse, a preventable and treatable behavioral health problem.

Goal: 0.27

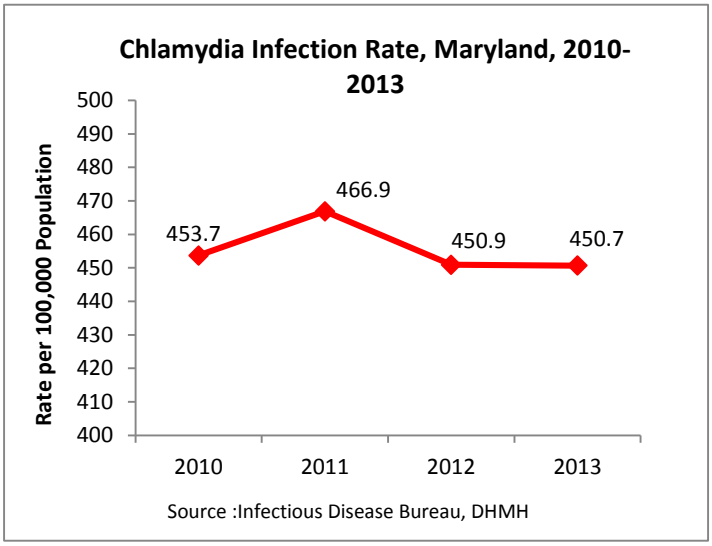


Trends: The rate of alcohol-impaired driving fatalities has consistently declined. The rate fell from 0.29 per 100 million vehicle miles traveled in 2009 to 0.15 in 2012 (a 48.3% decline), which is well below the target goal of 0.27. Therefore, the set goal of 0.27 per 100 million vehicle miles traveled has been achieved. At the county level, between 2009 and 2012, the average rates of alcohol-impaired driving fatalities in seven counties (Calvert, Caroline, Carroll, Charles, Garrett, Washington, and Worcester) were statistically significantly higher than the state average.

Chlamydia Incidence

This indicator shows the rate of Chlamydia infections per 100,000 population. In 2013, there were 26,723 reported Chlamydia cases in Maryland. Chlamydia infections are usually without symptoms and go undiagnosed. They are associated with pelvic inflammatory disease, infertility, ectopic pregnancy, and chronic pelvic pain.

Goal: 431.0

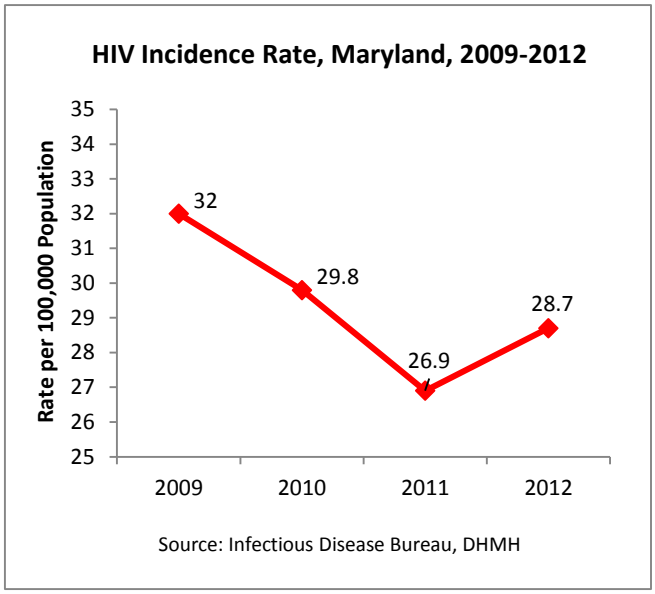


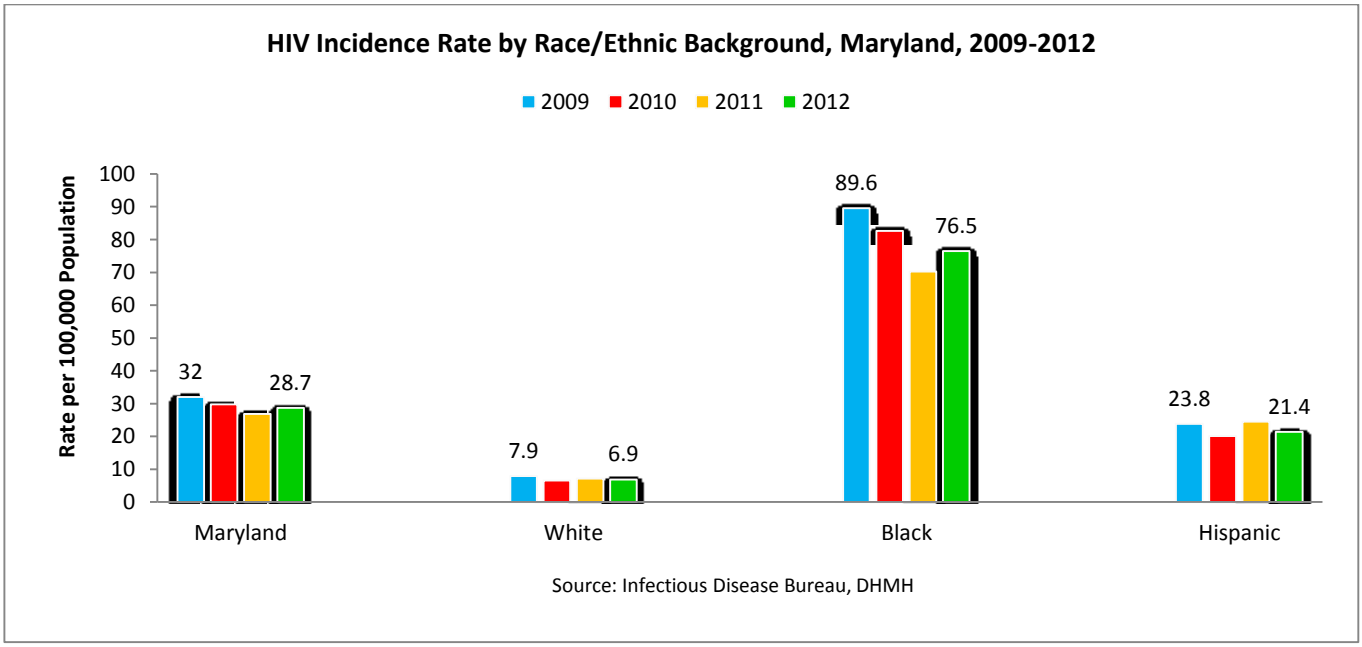
Trends: Chlamydia infection rate in Maryland has been stable. In 2010, the rate was 453.7 per 100,000 population. The rate slightly decreased to 450.7 per 100,000 in 2013. This 0.6% decline is not statistically significant. At the county level, the rates in Baltimore City, Caroline, Harford, St. Mary's, Somerset, and Wicomico declined substantially between 2010 and 2013. In contrast, the rates in Allegany, Anne Arundel, Calvert, Cecil, and Montgomery increased significantly during the same time period. Between 2012 and 2013, the rate in Allegany continued to increase. Also, Dorchester and Howard showed a significant increase during this period.

HIV Incidence

Human immunodeficiency virus (HIV) incidence is the estimated total number of new (total number of diagnosed and undiagnosed) HIV infections in a given period. HIV is a significant and preventable public health problem. HIV incidence estimates are used to monitor the HIV epidemic and to guide policies created to serve communities and population most affected by HIV. HIV incidence reflects the leading edge of HIV transmission, HIV infection trends, and the impact of HIV prevention efforts.

Trends: HIV incidence rate in Maryland has steadily declined in the past years. The rate fell from 32.0 per 100,000 population in 2009 to 26.9 in 2011, (a 15.9% decline). However, from 2011 and 2012, the rate increased from 26.9 to 28.7. This 6.7% increase is not statistically significant. While the overall target goal of 30.4 has been met, the incidence rates differ significantly by race and ethnicity. Blacks are disproportionately affected by HIV infection. Although the estimated rate of new HIV infections in all races have declined in the past years, the rate among blacks is significantly higher than other races. In 2012, the rate among blacks (76.5) was 11.1 times as high as the rate in whites (6.9). Baltimore City and Prince George's County, in which a majority (over 50%) of the population is African American, have the highest HIV incidence rate.



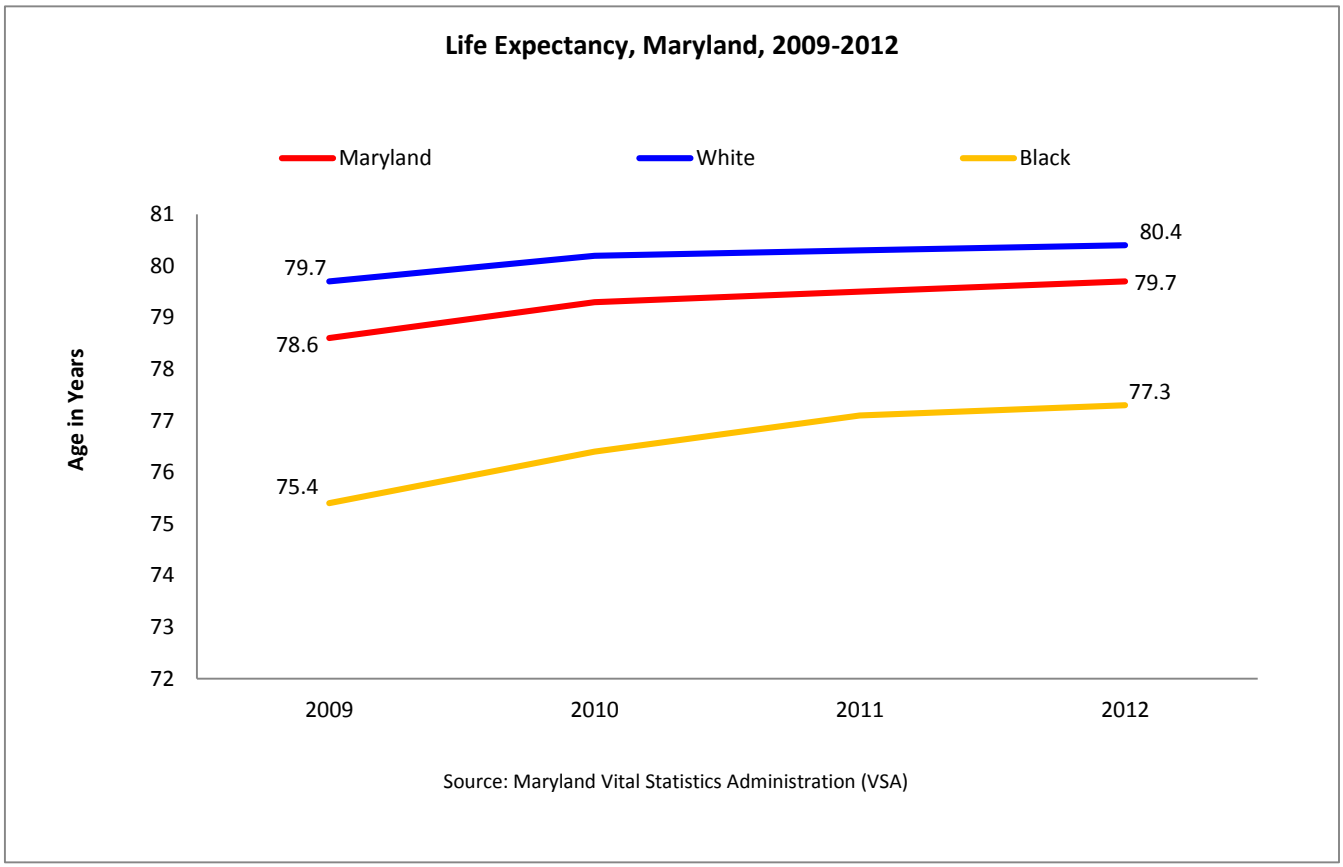


Life Expectancy

This indicator shows life expectancy from birth, in years. Life expectancy is a summary measure used to describe overall health. Life expectancy at birth is the average number of years a newborn is expected to live given current conditions. The life expectancy in the U.S. is the highest in recorded history thanks to public health interventions such as improvements in sanitation and food safety, development and use of vaccines, and health promotion efforts.

Goal: 82.5

Trends: From 2009 through 2012, life expectancy in Maryland increased from 78.6 years to 79.7 years. However, even with this statistically significant improvement, the target of 82.5 years was not achieved. For blacks, the life expectancy increased from 75.4 years to 77.3 years. For whites, the life expectancy increased from 79.7 years to 80.4 years. The life expectancy gap between whites and blacks has improved over the past years. The gap was 4.3 years in 2009 and it was 3.1 years in 2012. At the county level, life expectancy shows an increase in all counties except for Queen Anne's.



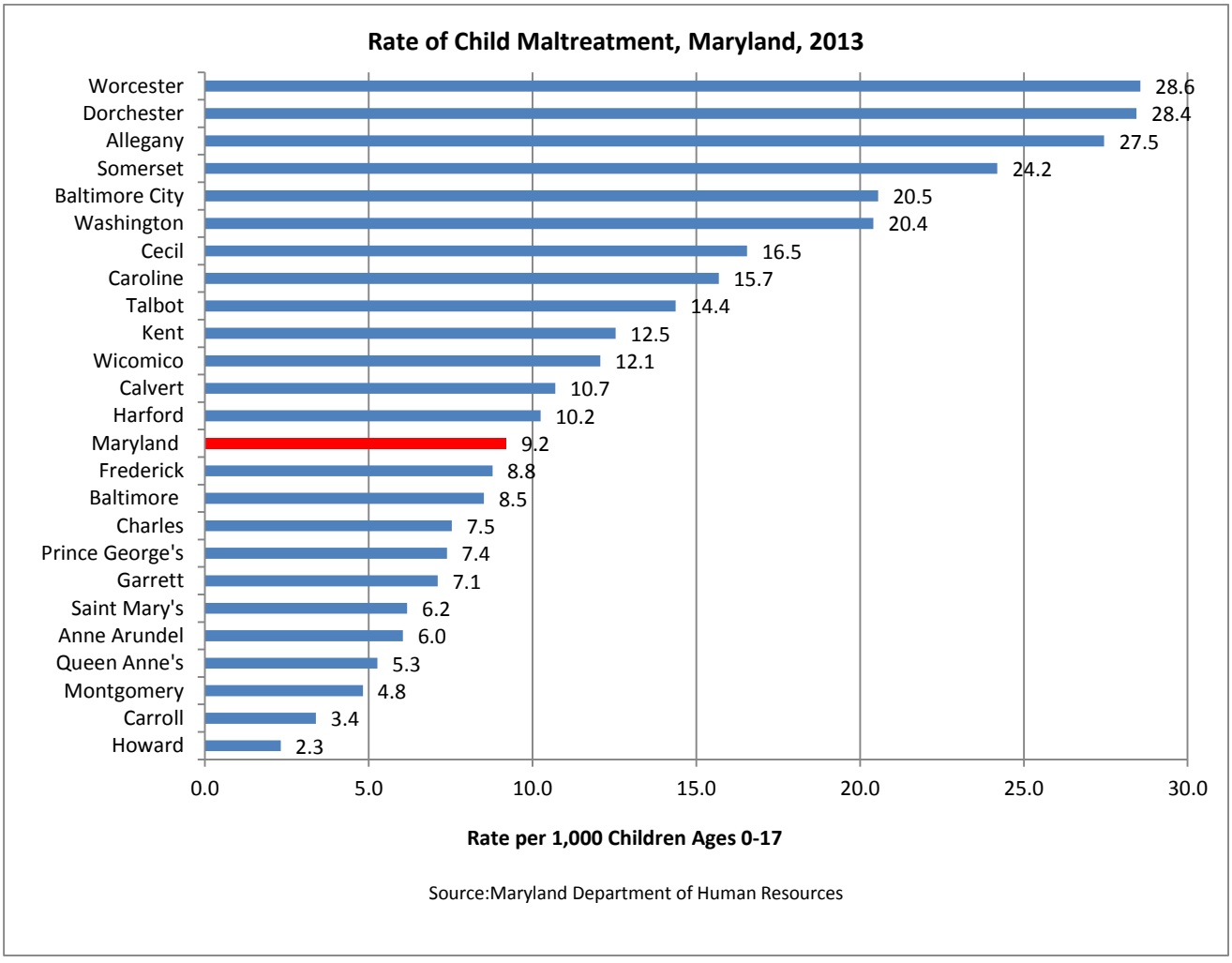
HEALTHY COMMUNITIES

Child Maltreatment

This indicator shows the rate of children who are maltreated per 1,000 population under the age of 18. Child abuse or neglect can result in physical harm, developmental delays, behavioral problems, or death. Abused and neglected children are at greater risk than other children for delinquency and mistreatment of their own children.

Goal: 4.8

Trends: In 2013, rate of child maltreatment in Maryland was 9.2 per 1,000 children ages 0-17. This is a 9.4% decline from the previous year, although close to the baseline of 9.3 in 2011 and well short of the target goal of 4.8. Moreover, despite this single year decrease on the state average, rates of child maltreatment in Allegany, Caroline, and Talbot increased significantly. In 2013, counties within the worst quartile for child maltreatment were Worcester (28.6), Dorchester (28.4), Allegany (27.5), Somerset (24.2), Baltimore City (20.5), and Washington County (20.4).

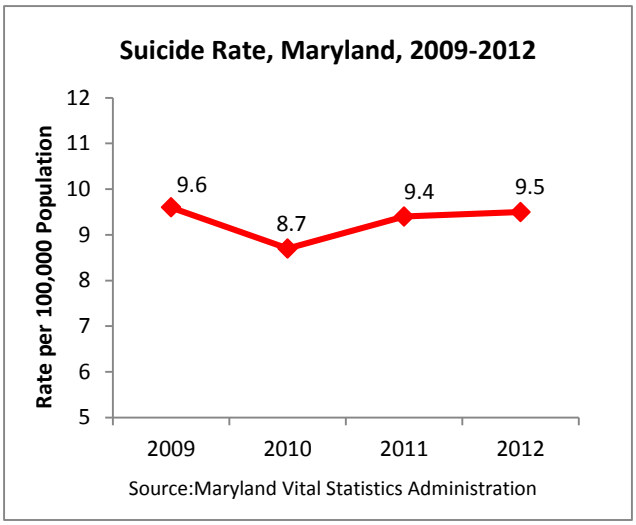


Source:Maryland Department of Human Resources

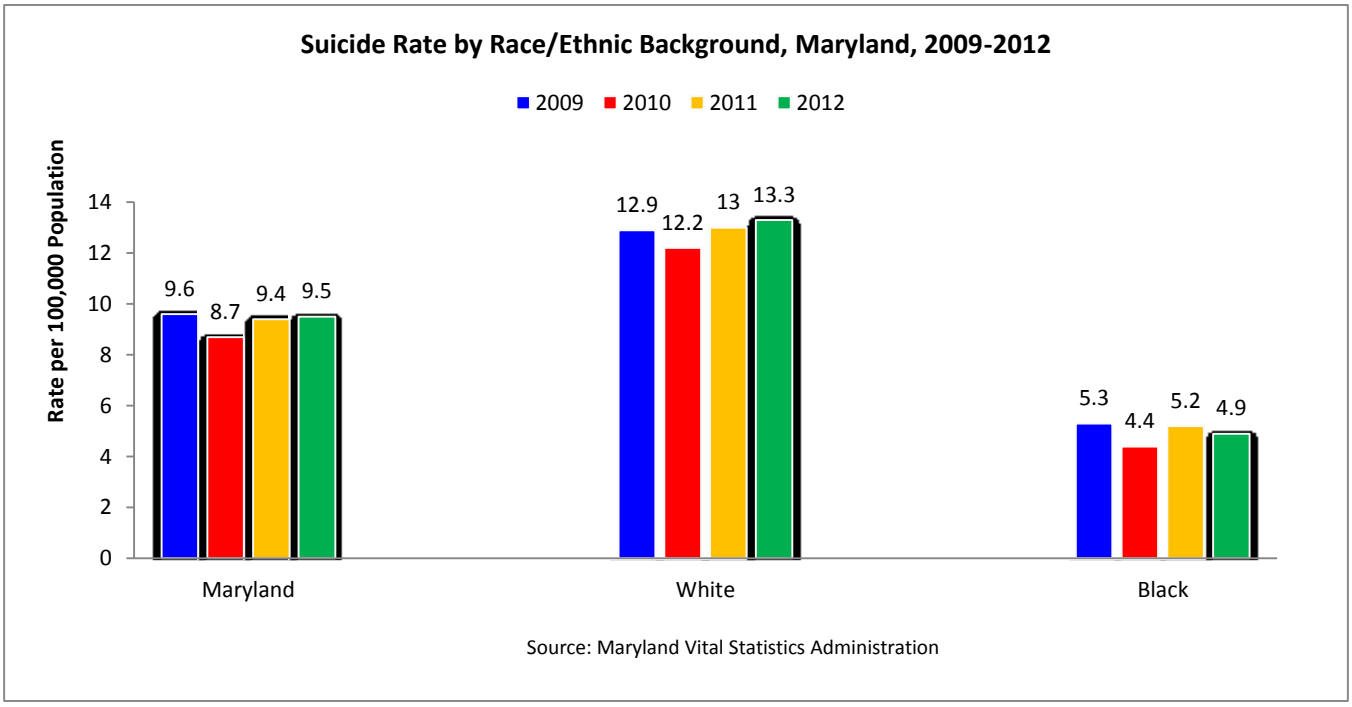
Suicide

This indicator shows the suicide rate per 100,000 population. Suicide is a serious public health problem that can have lasting effects on families and communities. Mental disorders and/or substance abuse have been found in the great majority of people who have died by suicide. In Maryland, approximately 500 lives are lost each year to this preventable cause of death.

Goal: 9.1



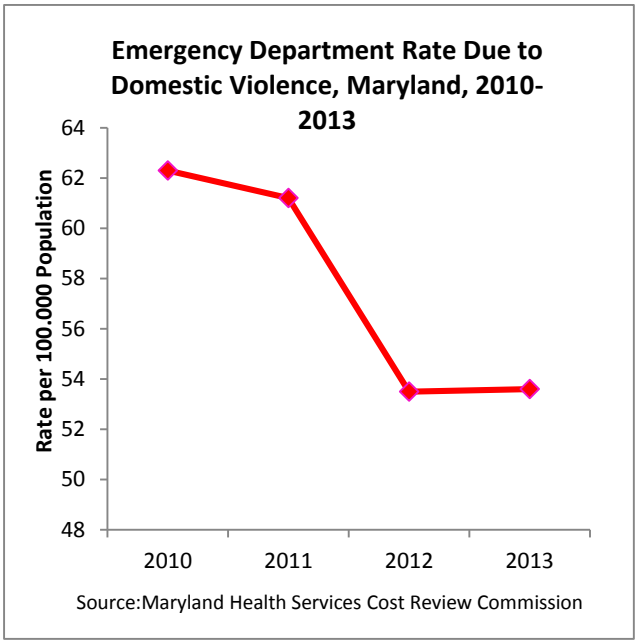
Trends: Suicide rate in Maryland has remained relatively stable since 2009. In 2013, the rate was 9.5 per 100,000. This is lower than the Healthy People 2020's goal of 10.2. Nevertheless, the rates differ among races. The rate among whites has been consistently higher than blacks. In 2013, the rate among whites was 13.3 per 100,000, but the rate among blacks was only 4.9 per 100,000 population. Similar to the state average, trends in all counties have remained relatively stable since 2007. In 2013, Prince George's had the lowest suicide rate (5.6), followed by Montgomery (7.4) and Baltimore City (8.6). In contrast, Calvert had the highest rate (14.9), followed by Cecil (14.4) and Worcester (14.2).



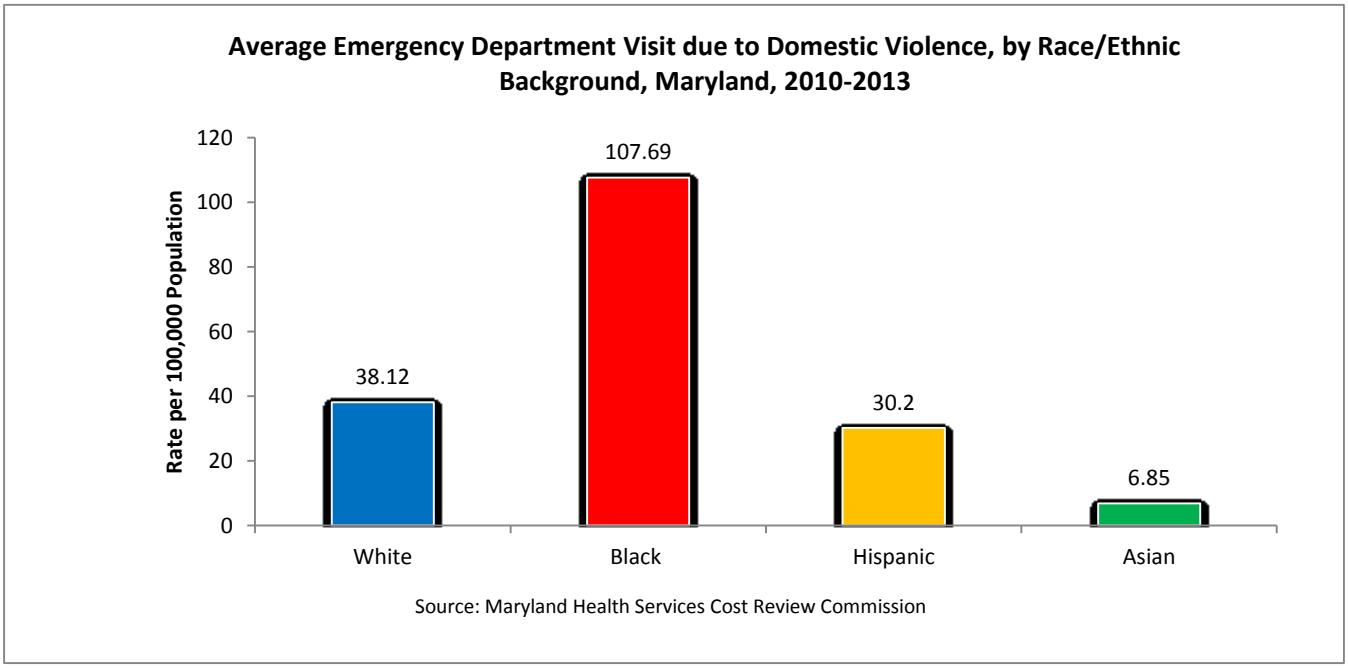
Emergency Department Visits due to Domestic Violence

This indicator shows the rate of emergency department visits related to domestic violence/abuse (per 100,000 population). Domestic violence contributes greatly to the morbidity and mortality of Maryland citizens. Up to 40% of violent juvenile offenders witnessed domestic violence in the homes, and 63% of homeless women and children have been victims of intimate partner violence as adults.

Goal: 59.2



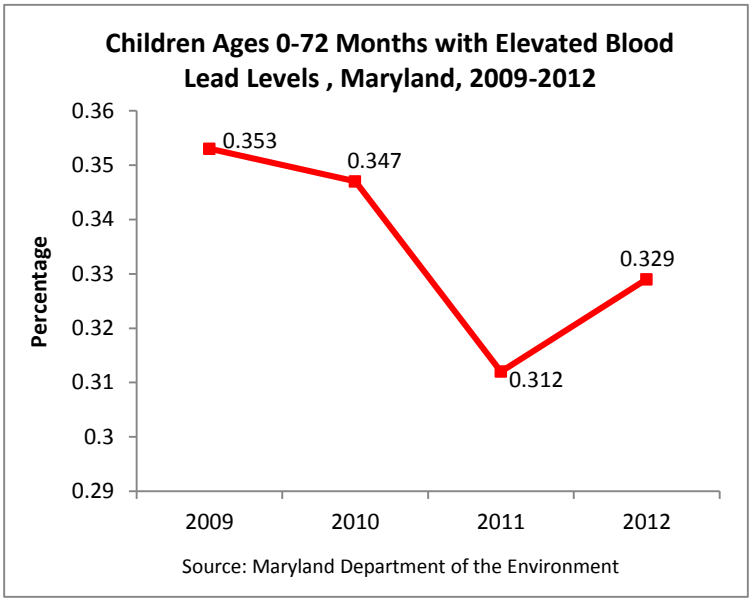
Trends: Between 2010 and 2012, the emergency department visit rate due to domestic violence fell from 62.3 to 53.5 per 100,000 population (a 14.1% decline). In 2013, the rate remained relatively stable compared with the rate in 2012. Between 2010 and 2013, six counties (Anne Arundel, Baltimore City, Carroll, Howard, Montgomery and St. Mary's) showed a significant decline, whereas three counties (Charles, Prince George's, and Wicomico) had a significant increase in the emergency department visit rate due to domestic violence. The data show that blacks are disproportionately affected by domestic violence. From 2010 through 2013, emergency department visit rate due to domestic violence was significantly higher among blacks than whites – the average rate among blacks was 107.7, whereas the rate among whites was 38.1 per 100,000.



Children with Elevated Blood Lead Levels

This indicator shows the percentage of children 0-72 months of age who have elevated blood lead levels (>10 µg/dL). Exposure to lead is the most widespread environmental hazard for children in Maryland. Lead paint dust from deteriorated lead paint or from renovation is the major source of exposure for children in Maryland. Children are at the greatest risk from birth to age six while their neurological systems are developing. There is no evidence of a blood lead level below which there are no health effects. Exposure to lead can cause long-term neurological damage that may be associated with learning and behavioral problems and with decreased intelligence. In Maryland, children are required to have a blood lead test at ages 1 and 2 years if they live in an identified "at-risk" zip code, or participate in Maryland Medicaid EPSDT Program, or positive response to "Risk Assessment Questionnaire" conducted on children up to age 6 years of age.

Goal: 0.177



Trends: In 2012, a total of 110,539 children under the age of 6 years were tested, and increase over the 2009 figure of 107,416 (an increase of 3,123 children tested). Of those 110,539 children tested in 2012, 364 (0.3%) were identified with a blood lead level ≥10 µg/dL. This was a decrease of 15 identified cases compared to 342 (0.4%) in 2009, although the decrease was not nearly large enough to meet the target goal of 0.177%. The percentage of children with elevated blood lead levels in Baltimore City has been the highest. In 2012, 219 children in Baltimore City were identified with elevated blood lead levels, or about 60.2% of total children identified in the state.

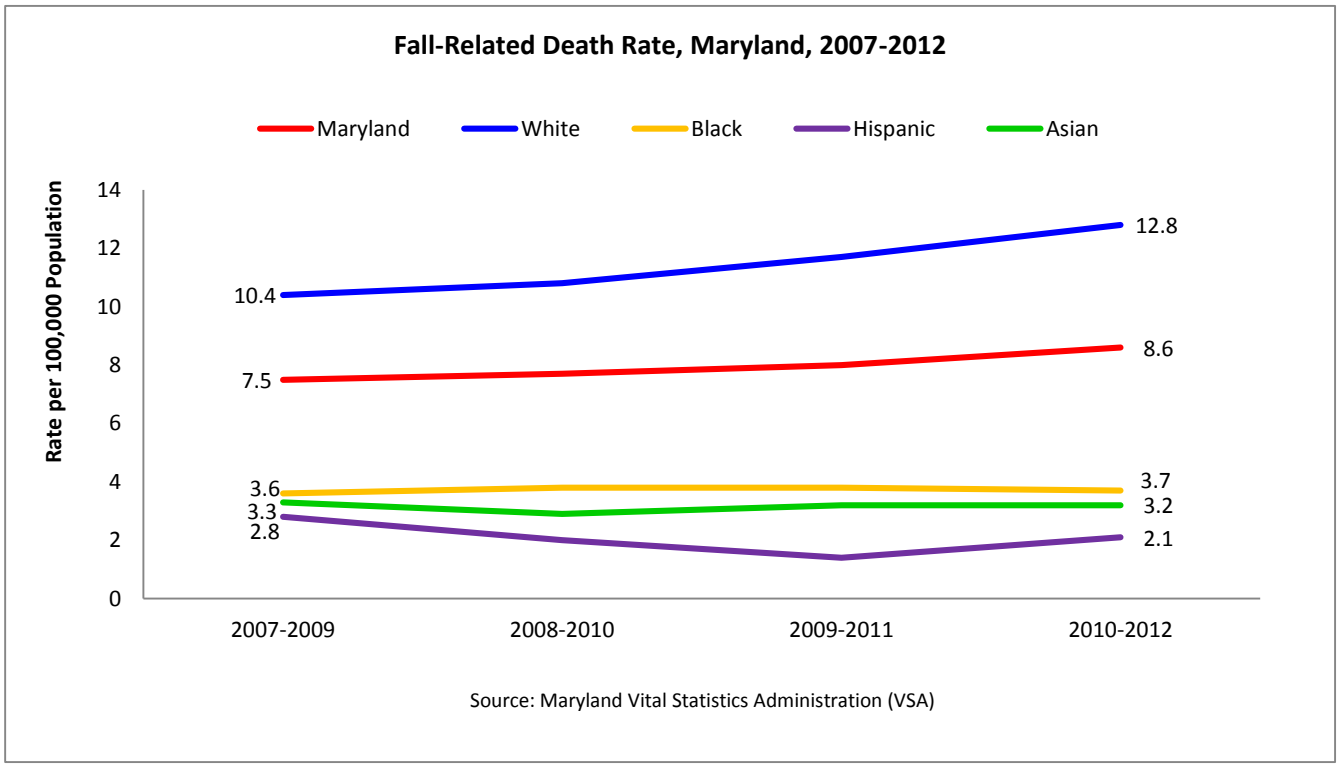
STATE STRATEGY

The Reduction of Lead Risk in Housing Act requires owners of pre-1950 rental dwelling units to reduce the potential for child exposure to lead paint hazards by performing specific lead risk reduction treatments prior to each change in tenancy. In addition, Maryland requires that children at ages one and two years who are enrolled in the Medicaid Early Periodic Screening, Diagnosis, and Treatment (EPSDT) program or who currently live or have ever lived in one of Maryland's "at-risk" zip codes identified by the "Targeting Plan" to have their blood lead levels tested. Finally, The Maryland Department of the Environment's statewide Childhood Lead Registry (CLR) performs childhood blood lead surveillance for Maryland. The CLR receives the reports of all blood lead tests conducted on Maryland children 0-18 years of age, and the CLR provides blood lead test results to DHMH. DHMH also coordinates with local health departments across the state to track testing results and identify children in need of testing.

Fall-Related Deaths

This indicator shows the rate of fall-related deaths per 100,000 population. Falls are a major cause of preventable death among the elderly and have increased across age groups in the past decade. Causes of fall-related deaths differ between the elderly and young and middle-aged population, and require different prevention strategies.

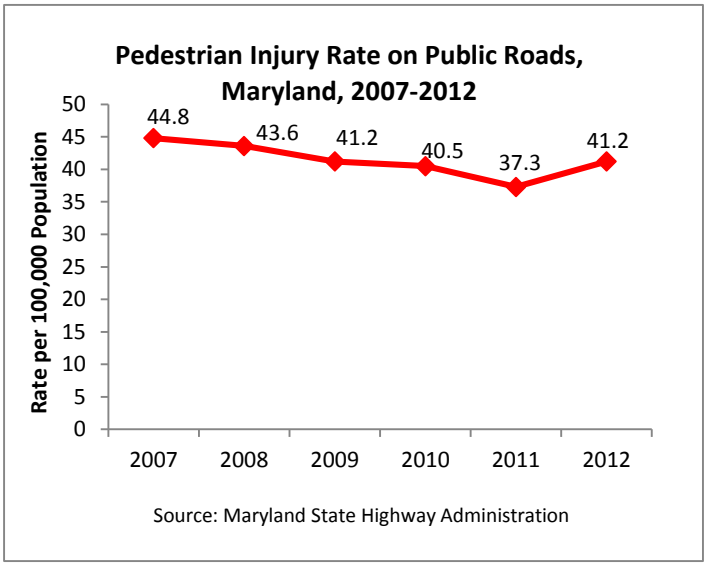
Trends: The fall-related death rate in Maryland increased from 7.5 to 8.6 per 100,000 between 2007 and 2012. Although this 14.7% increase is not statistically significant, the rate is considerably higher than the Healthy People 2020's goal of 7 per 100,000 population and Maryland's target goal of 6.9. Fall-related death rates vary by race and ethnic backgrounds. The rate among whites is the highest, whereas the rate among Hispanics is the lowest. In addition, the rate among white have increased over the past years, whereas the rates among the other have remained relatively unchanged. Trends have remained relative stable in all counties. In 2013, counties with the highest rates of fall-related death were Allegany (19.6), Caroline (14.1), Baltimore (13.9), and Kent (13.2).



Pedestrian Injuries

This indicator shows the rate of pedestrian injuries on public roads per 100,000 population. Maintaining pedestrian safety is a key element in preventing motor vehicle injuries and fatalities. There were 2,424 pedestrian injuries in Maryland in 2012. Children are especially at risk for pedestrian injuries and fatalities.

Goal: 29.7



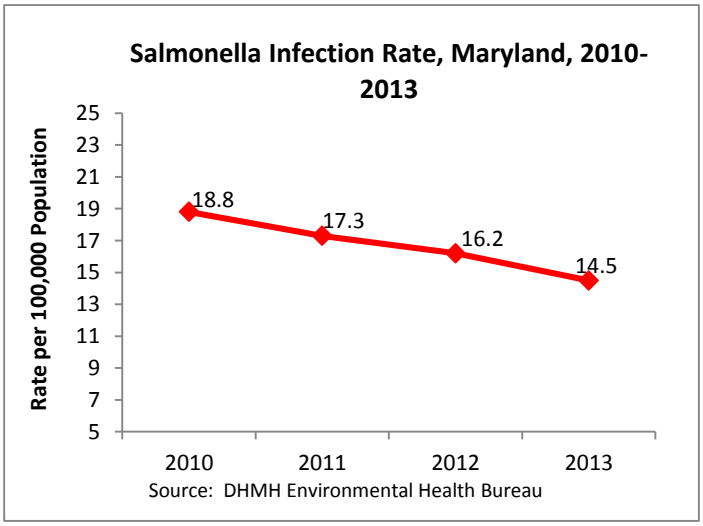
Trends: Pedestrian injury rate on public roads in Maryland decreased in 2008, 2009, 2010, and 2011, but increased in 2012. The rate in 2012 (41.2 per 100,000) was 8.0% lower than the rate in 2007 (44.8 per 100,000). Nevertheless, Maryland's rate is still well above than the Healthy People 2020 goal of 20.3 per 100,000 and the Maryland target goal of 29.7. Rates among counties vary substantially even though trends are relatively stable for all counties. The rates in Baltimore City and Worcester have been the highest due to tourist hot spots. Between 2010 and 2012, the rate in Baltimore City was 114.4 per 100,000 (2.8 times higher than the state norm), and the rate in Worcester was 72.5 per 100,000.

Salmonella Infection

This indicator shows the rate of Salmonella infections per 100,000 population. Salmonella infections due to contaminated food products make many people ill each year and are responsible for substantial economic costs. Salmonella infections are potentially serious and may be fatal, particularly for the elderly and people with weak immune systems.

Goal: 12.7

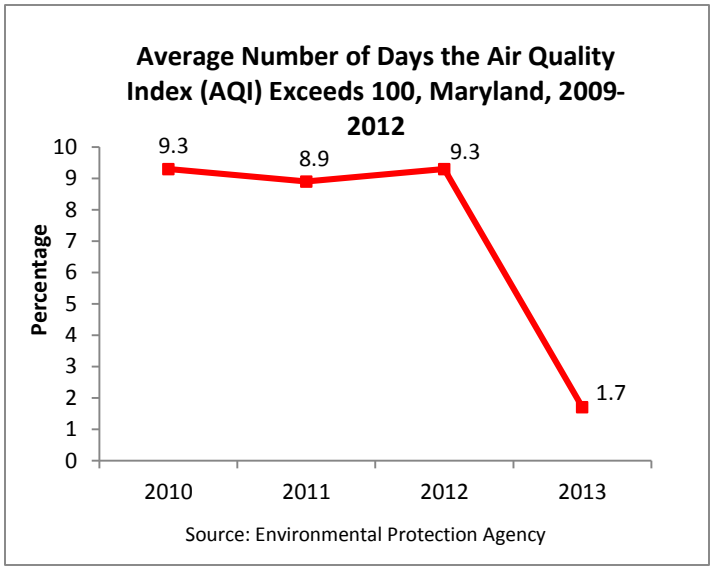
Trends: Salmonella infection rate in Maryland have fallen substantially over the past years from 18.8 per 100,000 in 2010 to 14.5 per 100,000 in 2013. This 22.8% decline was statistically significant. Despite this significant decrease, the rate is still higher than the target goal of 12.7 per 100,000. Salmonella infection rates differ substantially among Maryland counties. Between 2011 and 2013, counties in the worst quartile for salmonella infection were Dorchester (43.0), Caroline (37.7), Somerset (36.8), Wicomico (36.4), Worcester (34.9), and Baltimore City (30.8).



Unhealthy Air Days

This indicator shows the average number of days the Air Quality Index (AQI) exceeded 100. Poor air quality is associated with aggravation of asthma, premature death from heart and lung diseases, and increased acid conditions in lakes and streams.

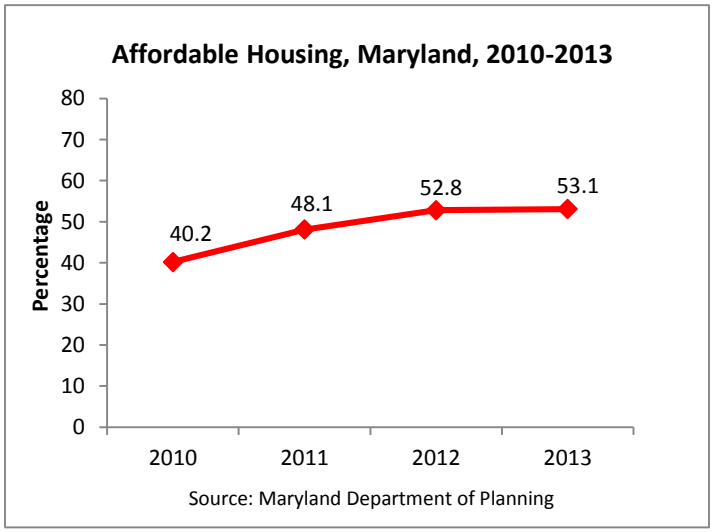
Trends: In 2013, the average number of unhealthy air quality days (AQI ≥ 100) declined substantially. It was 9.3 days in 2010, 8.9 days in 2011, 9.3 days in 2012, and 1.7 days in 2013, well below the target goal. In addition, the significant declines were found in all counties in the exception of Washington County, where the number was slightly changed. For instance, between 2012 and 2013, the number of unhealthy air quality days dropped from 13 days to 1 day in Anne Arundel County, from 14 days to 1 day in Baltimore County, from 16 days to 1 day in Kent, and from 17 days to 2 days for Prince George's. Cecil County had 4 unhealthy air quality days in 2013, the highest number of unhealthy air quality days in the state.



Affordable Housing

This indicator shows the percentage of housing units sold that are affordable on the median teacher's salary. Affordable housing can improve health by providing greater stability and reducing stress. Having affordable housing can allow family resources to be used for other needs like healthy food and health care.

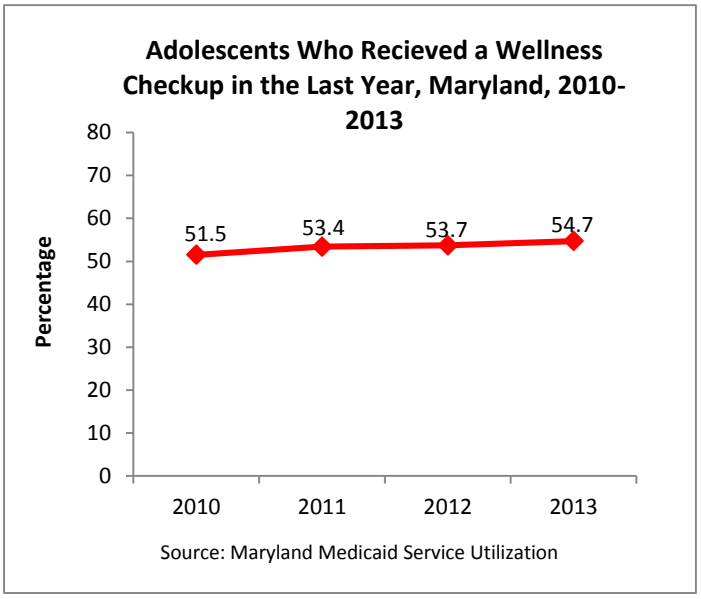
Trends: Housing units sold that are affordable on the median teacher's salary in Maryland have increased substantially over the past years from 40.2% in 2010 to 53.1% in 2013 (a 32.1% increase) to surpass the state target goal. The percentages of affordable housing units differ substantially among Maryland's counties. In 2013, housing units in Allegany (94.6%), Wicomico (83.6%), and Baltimore City (81.9%) were the most affordable in the state. In contrast, housing units in Howard (22.3%), Queen Anne's (25.7%), and Carroll (26.4%) were the most expensive.



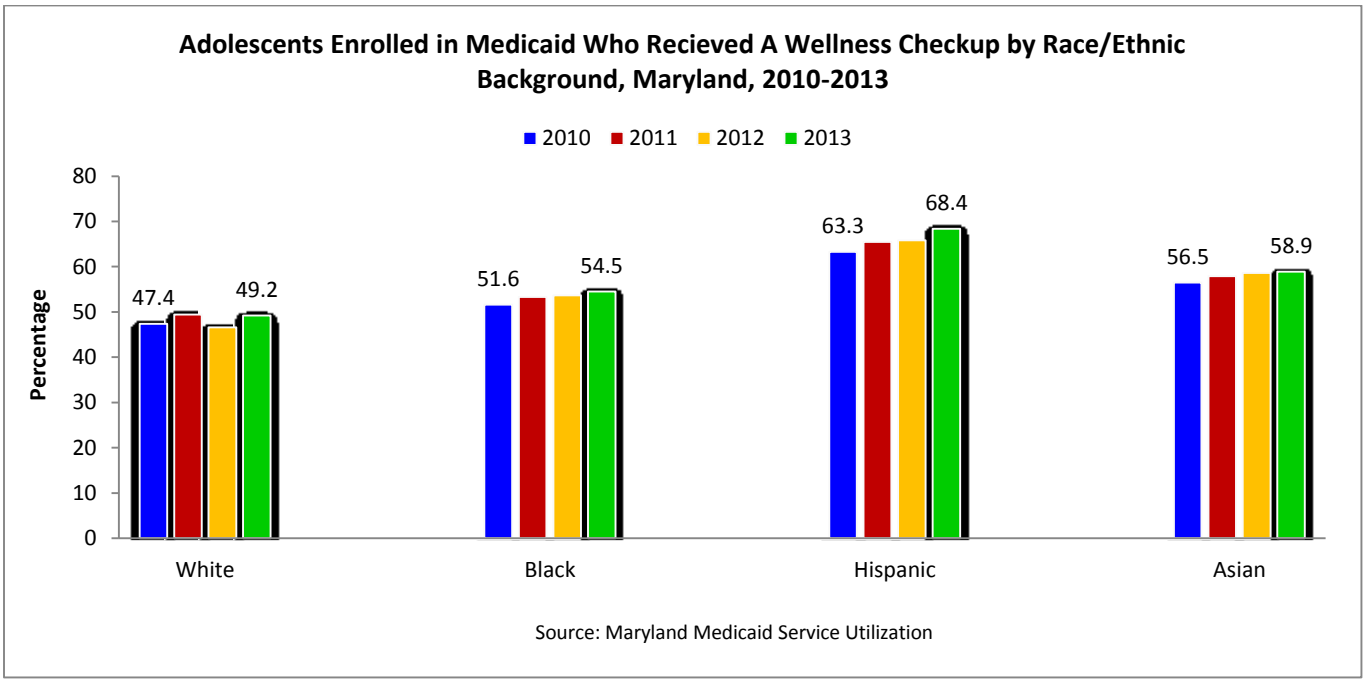
ACCESS TO HEALTH CARE

Adolescents Receiving a Wellness Checkup

This indicator shows the percentage of adolescents (ages 13-20 years old) enrolled in Medicaid (320+ days) who received a wellness visit during the past year. Many health and social problems peak in adolescence (homicide, suicide, motor vehicle crashes, substance use and abuse, smoking, sexually transmitted infections, HIV, unplanned pregnancies, and homelessness). Receiving annual wellness checkups can help detect and prevent the development of these problems in adolescence and later in life.



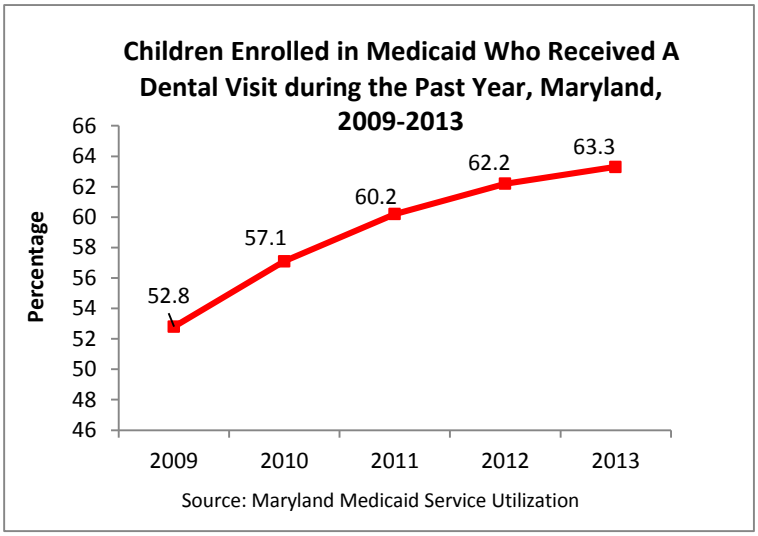
Trends: The percentage of adolescents enrolled in Medicaid who received a wellness visit during the past year increased from 51.5% in 2010 to 54.7% in 2013, surpassing the target goal of 54.3%, achieving the state's goal of 54.3%. However, the percentages vary greatly by county. In 2013, the highest percentages were found in Montgomery (63.1%), Somerset (60.5%), Talbot (59.4%), and Howard (56.2%). The lowest percentages were found in Garrett (42.9%), Charles (46.2%), Queen Anne's (46.6%), and St. Mary's (47%). The percentages also differ among race and ethnic backgrounds. Hispanic adolescents have the highest percentage of those who received a wellness checkup, whereas whites have the lowest percentage.



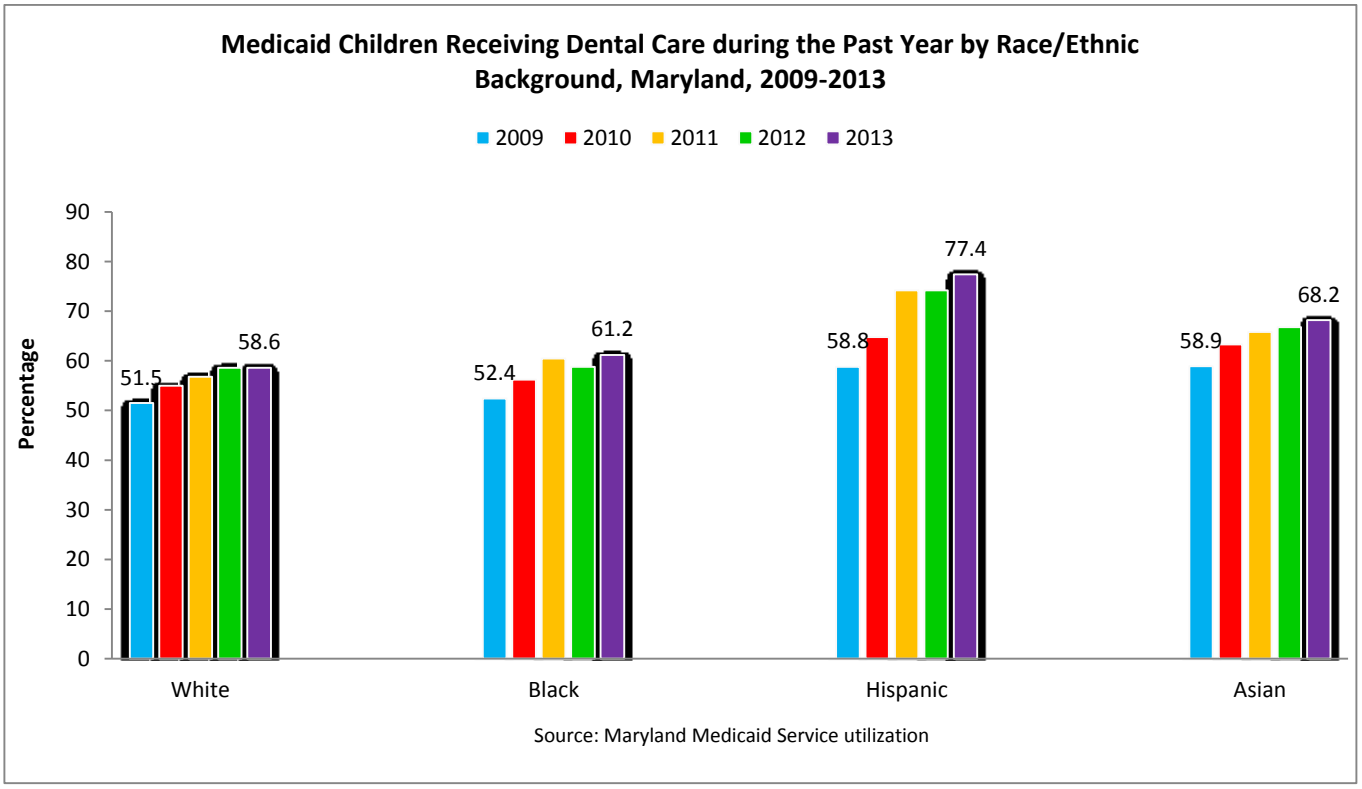
Children Receiving Dental Care

This indicator shows the percentage of children (aged 0-20 years) enrolled in Medicaid (320+ days) who had a dental visit during the past year. Diseases of the teeth and gum tissues can lead to problems with nutrition, growth, school and workplace readiness, and speech. Adoption and use of recommended oral hygiene measures are critical to maintaining overall health.

Goal: 55.4



Trends: Overall, the percentage of Medicaid children having a dental visit has increased substantially in the past years. From 2009 through 2013, the percentage increased from 52.8% to 63.3% (a 19.9% increase) and achieved the state's target goal of 55.4%. A similar improvement has been reported for all counties with the exception of Garrett, where the percentage of children enrolled in Medicaid receiving a dental visit has declined. The improvement has also been found in all races. The largest improvement has been reported for Hispanics (a 31.6% increase).

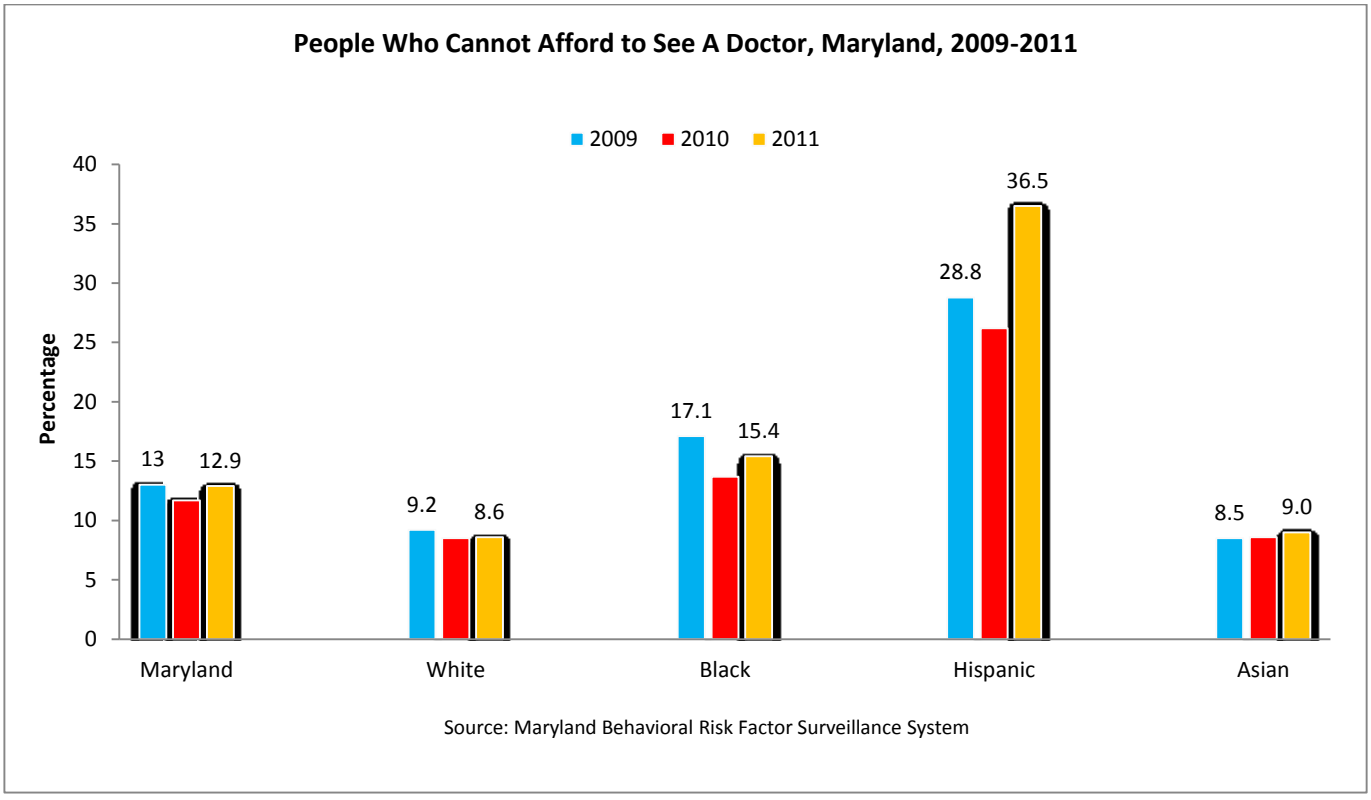


People Who Cannot Afford to See a Doctor

This indicator shows the percentage of people who were unable to see a doctor due to costs. Most of these people are uninsured or had inadequate health insurance. Also, some people with good health insurance also have to forgo treatment because of the price.

Goal: 11.4

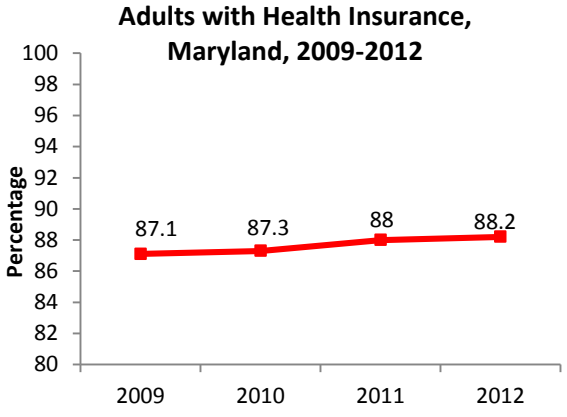
Trends: The percentage of people who were unable to see a doctor due to costs in Maryland was 12.9% in 2013. There was no statistically significant change from the year 2011, when the percentage was 13.0%. The target goal of 11.4% was not met, which may be attributed to large racial/ethnic disparities. Hispanic people are more likely to forgo treatment because of costs. In 2013, 36.5% of Hispanics were unable to see a doctor due to costs, whereas there were only 8.6% of whites, 9.0% of Asians, and 15.4% of blacks who had this problem. In addition, the percentage of Hispanics who could not see a doctor because of costs increased significantly from 28.8% in 2011 to 36.5% in 2013; the percentages in the other races remained relatively stable. The percentages also vary largely by counties. Between 2011 and 2013, Allegany (17.7%), Baltimore City (17.6%), Prince George's (17.2%), and Kent (17%) had the highest proportion of people who were unable to afford to see a doctor.



Adults with Health Insurance

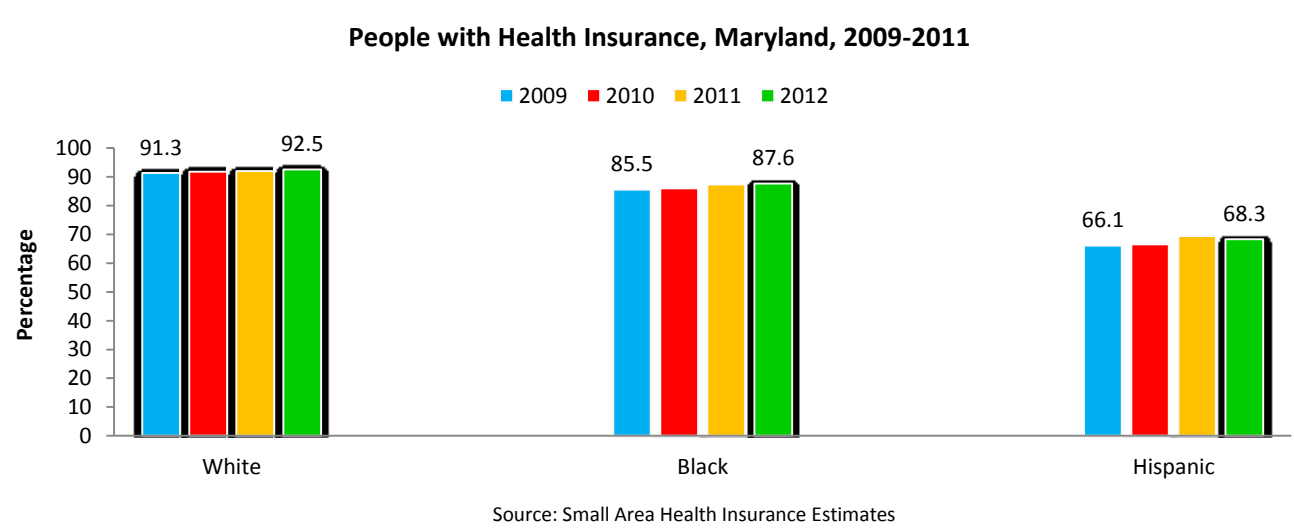
This indicator shows the percentage of persons aged 18-64 with health insurance. People without health insurance are more likely to be in poor health than the insured. Lack of health insurance can result in increased visits to the emergency department and decreased routine care visits with a primary care provider.

Goal: 93.6



Source: Small Area Health Insurance Estimates

Trends: The percentage of people aged 18-64 with health insurance increased slightly from 87.1% in 2009 to 88.2% in 2012. Between 2009 and 2012, the percentage of insured individuals increased in all counties except Montgomery, where the percentage declined by 0.34%. During the same time period, Caroline, Baltimore City, Kent, and Somerset showed the largest change where the percentage increased by 4.0% in Caroline, 3.5% in Baltimore City, 3.5% in Kent, and 3.4% in Somerset. Trends among races have remained relatively stable. Hispanics people have the lowest percentage of people with health insurance. In 2012, only 68.3% of Hispanics were insured, whereas 92.5% of whites and 87.6% of blacks were insured, respectively.



Source: Small Area Health Insurance Estimates

NOTE

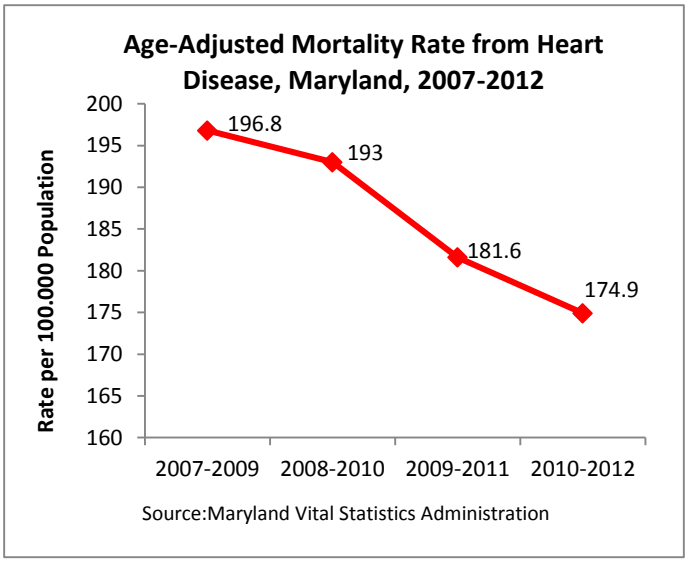
These data represent the period before implementation of Medicaid expansion and the Maryland Health Benefits Exchange, which has expanded coverage to tens of thousands of Marylanders since 2013. For up-to-data on health insurance coverage, please visit www.marylandhbe.com.

QUALITY PREVENTIVE CARE

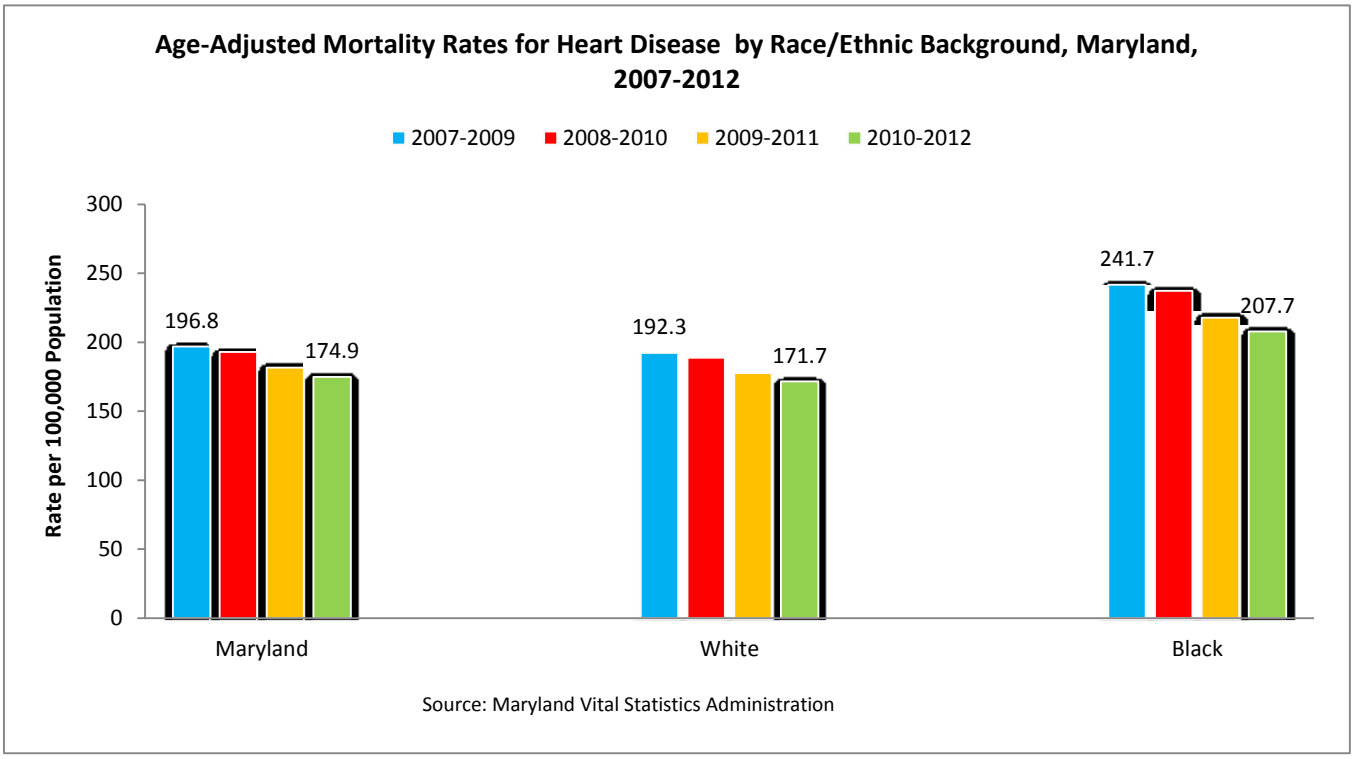
Deaths from Heart Disease

This indicator shows the age-adjusted mortality rate from heart disease (per 100,000 population). Heart disease is the leading cause of death in Maryland, accounting for 25% of all deaths.

Goal: 173.4



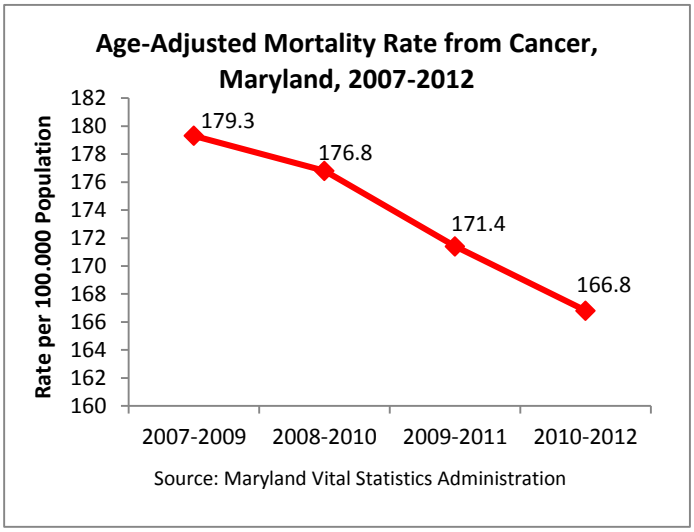
Trends: The age-adjusted mortality rate for heart disease in Maryland has continuously declined since 2007. Between 2010 and 2012, the rate was 174.9 per 100,000 population, an 11.1% decrease from 2007. However, the rate is still higher than the Healthy People 2020's goal of 152.7. At the county level, Allegany, Baltimore City, Caroline, Somerset, and Wicomico have been consistently listed among top 5 counties for the age-adjusted mortality for heart disease. For instance, between 2010 and 2012, the rate in Somerset was a 51.7% higher than the state average. In addition, the rates among blacks have been higher than whites.



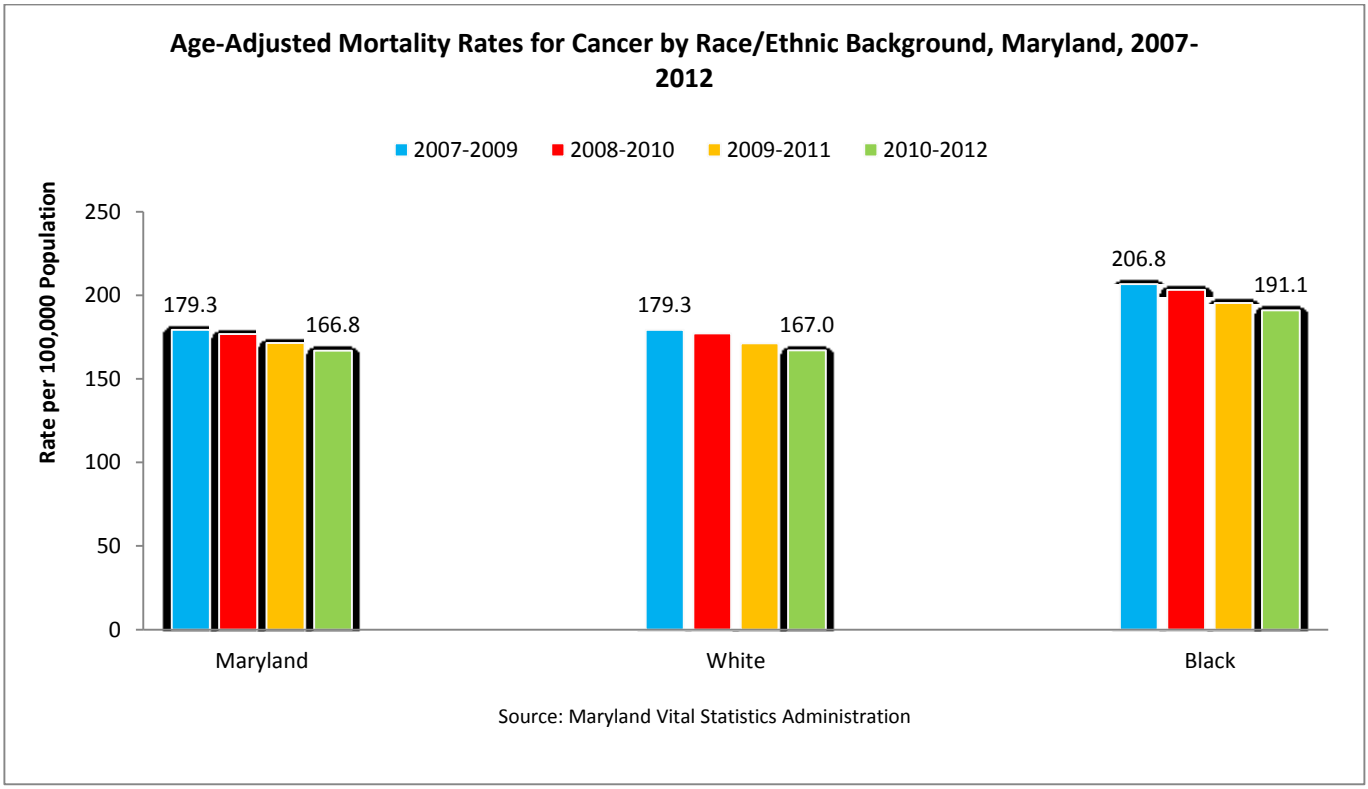
Deaths from Cancer

This indicator shows the age-adjusted mortality rate from cancer (per 100,000 population). Cancer is the second leading cause of death in Maryland behind heart disease. Cancer impacts people across all population groups, however wide racial disparities exist.

Goal: 169.2



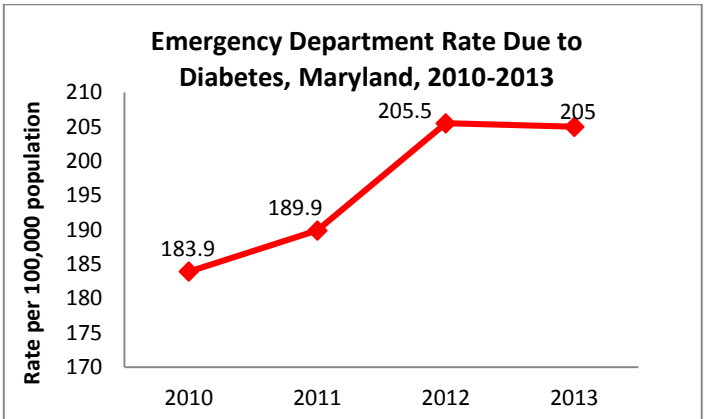
Trends: The age-adjusted mortality rate for cancer in Maryland has continuously declined since 2007. Between 2010 and 2012, the rate was 166.8 per 100,000 population, a 7.5% decrease from the rate of 179.3 between 2007 and 2009. However, the rate is still higher than the Healthy People 2020's goal of 160.6. At the county level, the rates in Baltimore City and Somerset have been consistently among the highest. Between 2010 and 2012, the rate in Baltimore City was 215.2 and the rate in Somerset was 228.0 per 100,000. In addition, the rates among blacks have been higher than whites.



Emergency Department Visits Due to Diabetes

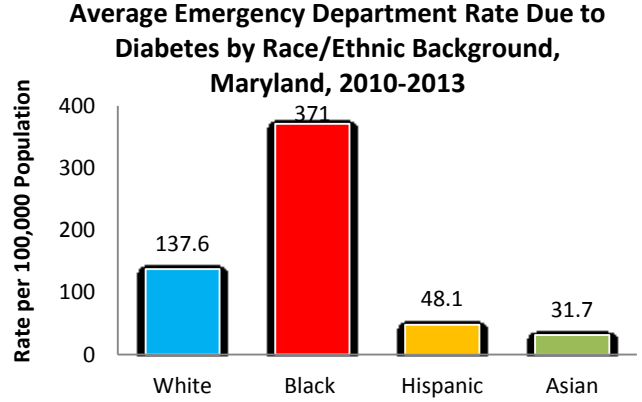
This indicator shows the emergency department visit rate due to diabetes (per 100,000 population). Diabetes can lead to blindness, heart and blood vessel disease, stroke, kidney failure, amputations, nerve damage, pregnancy complications and birth defects. Emergency department visits for diabetes-related complications may signify the disease is uncontrolled.

Goal: 174.4



Source:Maryland Health Services Cost Review Commission

Trends: The emergency department visit rate due to diabetes was 205.0 per 100,000 population in 2013, an 11.4% increase over the rate of 183.9 in 2010. Between 2010 and 2013, the rates in nine counties (Allegany, Baltimore City, Carroll, Cecil, Howard, Kent, Montgomery, Prince George's, and Queen Anne's) significantly increased. From 2012 to 2013, the statewide rate was steady. Only Carroll County showed a significant increase. On the other hand, the rate in Caroline County significantly declined over this period.



Source: Maryland Health Services Cost Review Commission

The data show that blacks are disproportionately affected by diabetes. From 2010 through 2013, the emergency department visit rate due to diabetes was significantly higher among blacks than whites – the average rate among blacks was 371.0, whereas the rate among whites was 137.6 per 100,000 population.

PROMISING LOCAL STRATEGY

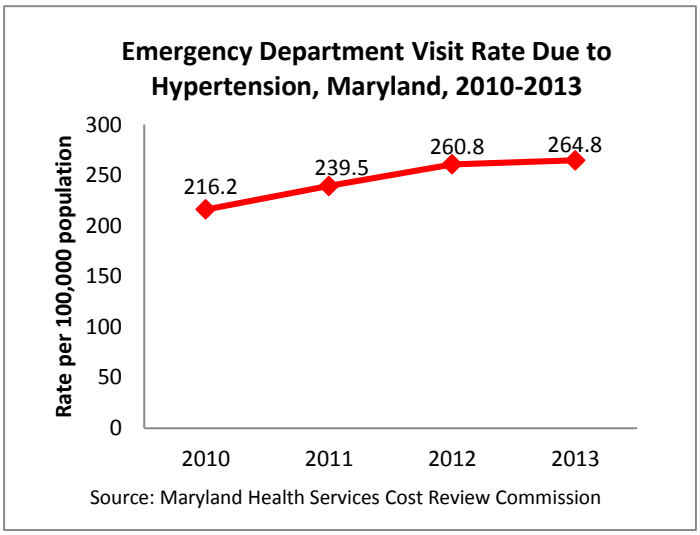
The **Tri-County Health Improvement Planning Coalition** received a grant from the Maryland Community Health Resources Commission to support its efforts to prevent diabetes in Somerset, Wicomico, and Worcester Counties. The goal for the project was for the three health departments to become recognized by the CDC as authentic providers of the National Diabetes Prevention Program, renamed locally as "Lifestyle Balance" and, ultimately, to reduce the prevalence of diabetes. This evidence-based program promotes healthy eating, physical activity, and weight loss to prevent and delay diabetes. The funding was used to train and certify lifestyle coaches and to implement the Lifestyle Balance program in each of the three counties. The project was successful, with a total of 97 individuals completing the program, a 218% improvement in consumption of fruits and vegetables, and a 382% increase in physical activity with a target of 150 minutes/week.

Emergency Department Visits Due to Hypertension

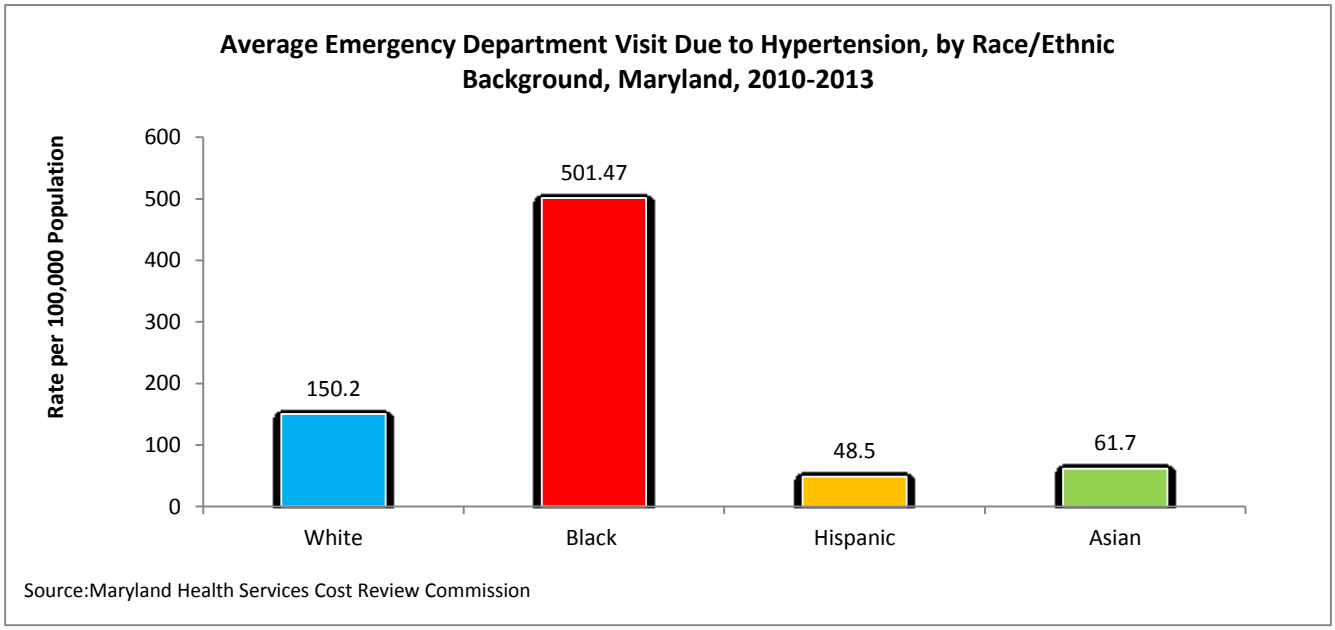
This indicator shows the emergency department visit rate due to hypertension (per 100,000 population). High blood pressure can cause hardening and thickening of the arteries (atherosclerosis), which can lead to heart disease and cerebrovascular diseases, which are two major leading cause of death in Maryland. Emergency department visit for hypertension may signify that there is an unmet need for patients to have better help controlling their blood pressure in the outpatient setting.

Goal: 205.4

Trends: The emergency department visit rate due to hypertension was 264.8 per 100,000 in 2013, a 22.5% increase over the rate of 216.2 in 2010. During this time period, the rates in all counties except Calvert, Caroline, Garret, Harford, Howard, St. Mary's, Somerset, Talbot, Washington, and Wicomico showed a significant increase. From 2012 to 2013, the statewide rate remained stable; the only statistically increase occurred in Cecil County. The rate in St. Mary's County significantly declined, where the rate fell by 14% between the two years.



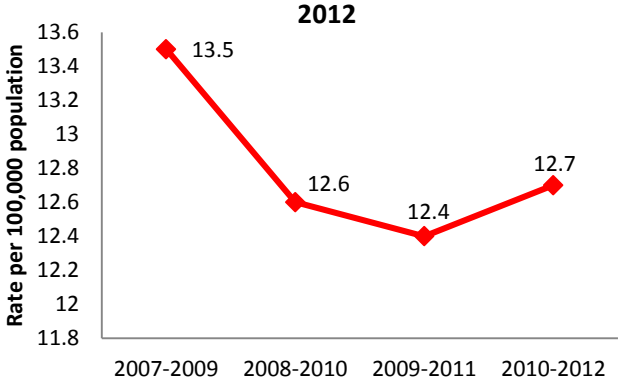
The data show that blacks are disproportionately affected by hypertension. From 2010 through 2013, emergency department visit rate due to hypertension was significantly higher among blacks than whites – the average rate among blacks was 501.5, whereas the rate among whites was 150.2 per 100,000. This trend is consistent regardless of geography.



Drug-Induced Deaths

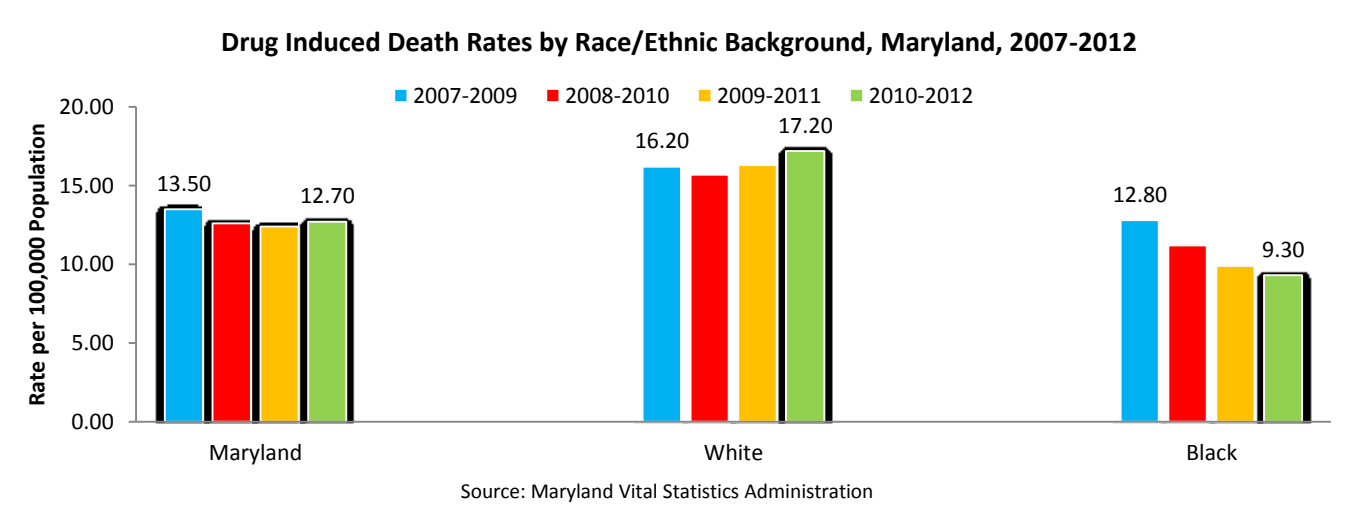
This indicator shows the drug-induced death rate per 100,000 population. Drug-induced deaths include all deaths for which illicit or prescription drugs are the underlying cause. In 2007, drug-induced deaths were more common than alcohol induced or firearm-related deaths in the United States. In 2012, there were 839 drug-induced deaths in Maryland.

Goal: 12.4



Source: Maryland Vital Statistics Administration

Trends: The average drug induced death rate in Maryland for the year period 2010-2012 was 12.7 per 100,000 population. This was a 6% decrease from the period 2007-2009 (13.5 per 100,000 population) but an increase from the previous year, which tied the target goal of 12.4. At the county level, the rate is higher than 12.4 in all counties except Montgomery, Prince George's, Howard, St. Mary's, Frederick, Charles and Carroll. The rates among whites have been consistently higher than the rates among blacks. Between 2007 and 2012, the rate among whites was relatively stable. In contrast, during the same time period, the rate among blacks significantly declined.



Source: Maryland Vital Statistics Administration

PROMISING LOCAL STRATEGY

The **Cecil County Community Health Advisory Committee** chose issues surrounding substance abuse for targeted action in the community as drug-related deaths sharply increased in recent years. A needs assessment was conducted to evaluate the effectiveness of current services and programs. Results suggested that Cecil County has one of the highest rates of overdose deaths in the state, particularly around heroin use. In order to improve service effectiveness, Cecil County is using evidence-based strategies including LifeSkills Training to encourage prevention, 12-step therapies as a form of treatment, and collaboration with law enforcement and community agencies to dissuade substance use.

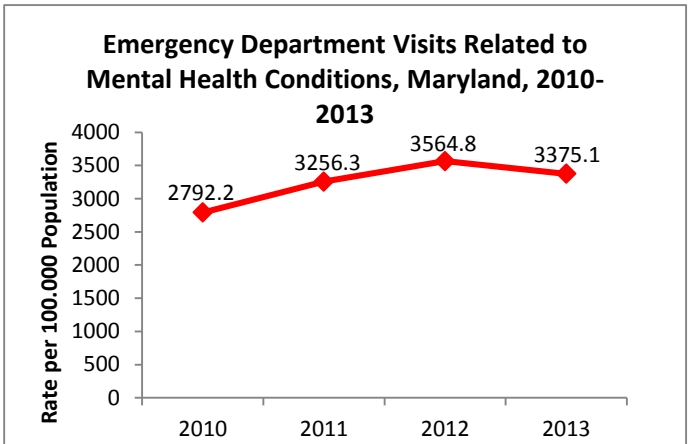
Emergency Department Visits Related to Mental Health Conditions

This indicator shows the rate of emergency department visits related to mental health disorders (per 100,000 population). Mental health problems can place a heavy burden on the health care system, particularly when persons in crisis utilize emergency departments instead of other sources of care when available.

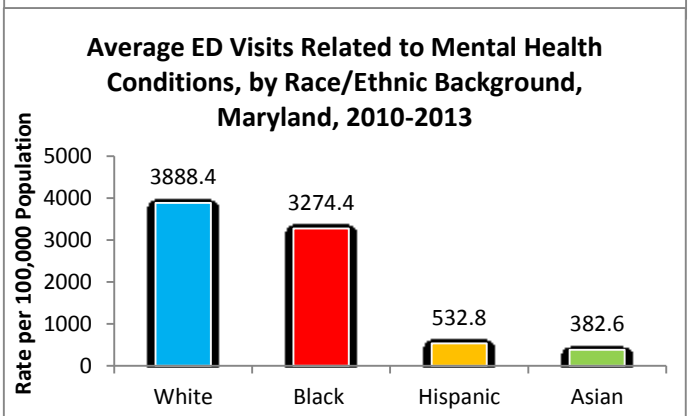
Goal: 2652.6

Trends: Emergency department visit rate related to mental health conditions was 3,375.1 per 100,000 in 2013, a 20.9% increase over the rate of 2,792.2 in 2010. This was a statistically significant increase and well in excess of the state target of 2,652.6. Between 2010 and 2013, only Harford County showed a statistically significant decline. During the same period, the rates in Baltimore County, Caroline, and Talbot were steadily stable, whereas the rates in other counties were significantly higher.

However, between 2012 and 2013, the statewide rate fell significantly by 5.3%. In addition, during the same time period, 8 counties (Baltimore, Cecil, Dorchester, Frederick, Harford, Queen Anne's, Talbot, and Washington) showed a significant decline. The rates among whites and blacks have been significantly higher than Asians and Hispanics. Between 2010 and 2013, the rate among whites increased by 13.8%, whereas the rate among blacks increased by 17.0%.



Source: Maryland Health Services Cost Review Commission



Source: Maryland Health Services Cost Review Commission

PROMISING LOCAL STRATEGY

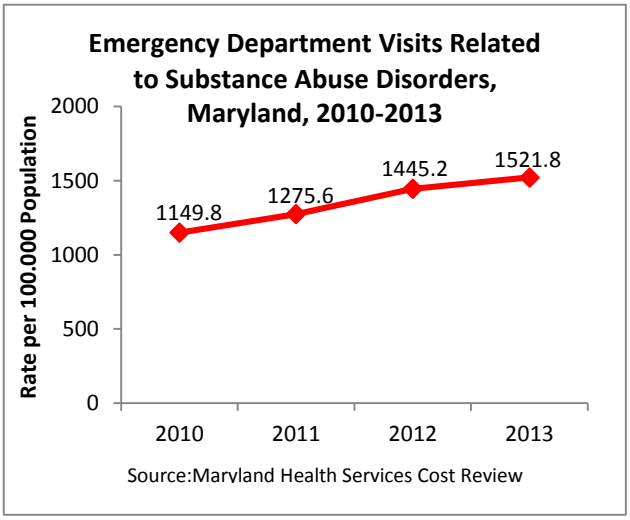
The **Healthy Montgomery County Local Health Improvement Coalition** developed a comprehensive approach to addressing the emotional and mental health needs of its community. A task force was convened to formulate a framework to establish a coordinated system of care in Montgomery County. Partners from various sectors of the community joined together to provide support and increase social connectedness. For example, they increased dissemination of information about the availability of behavioral health services to the public and referral agencies increased utilization and tracking information to coordinate efforts and assets across the continuum. Organizational connection and greater utilization of existing mental health assets have also resulted in improvements in treatment of mental health conditions.

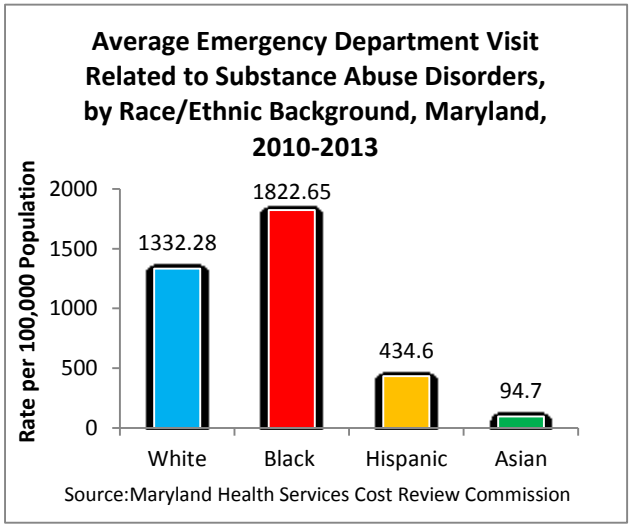
Emergency Department Visits for Addictions-Related Conditions

This indicator shows the rate of emergency department visits related to substance use disorders (per 100,000 population). Substance use problems can place a heavy burden on the health care system, particularly when persons in crisis utilize emergency departments instead of other sources of care when available.

Goal: 1092.3

Trends: Emergency department visit rate related to substance use disorders was 1,521.8 per 100,000 in 2013, a 32.4% increase over the rate of 1,149.8 in 2010. This was a statistically significant increase. From 2010 to 2013, all counties (except Calvert, Caroline, and Dorchester) had a statistically significant increase in the rate of emergency department visit related to substance abuse disorders. Between 2012 and 2013, although the rates in ten counties (Allegany, Baltimore City, Charles, Garrett, Harford, Montgomery, Prince George's, St. Mary's, Washington, and Wicomico) were statistically significantly higher, three counties (Carroll, Cecil, and Frederick) showed statistically significant declines. In addition, the rates differ among race/ethnic backgrounds. The rate among blacks has been the highest compared to other races. Between 2010 and 2013, the rate among blacks increased from 1,493.6 to 2,065.6 per 100,000 (a 38.3% increase). In contrast, during the same period, the rate among whites increased by 15.0% (from 1,198.1 to 1,378.2 per 100,000).



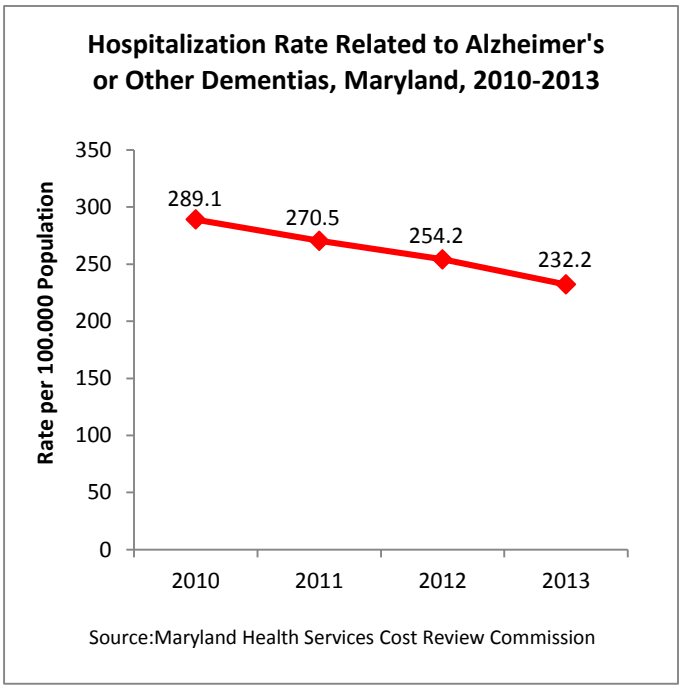


PROMISING LOCAL STRATEGY

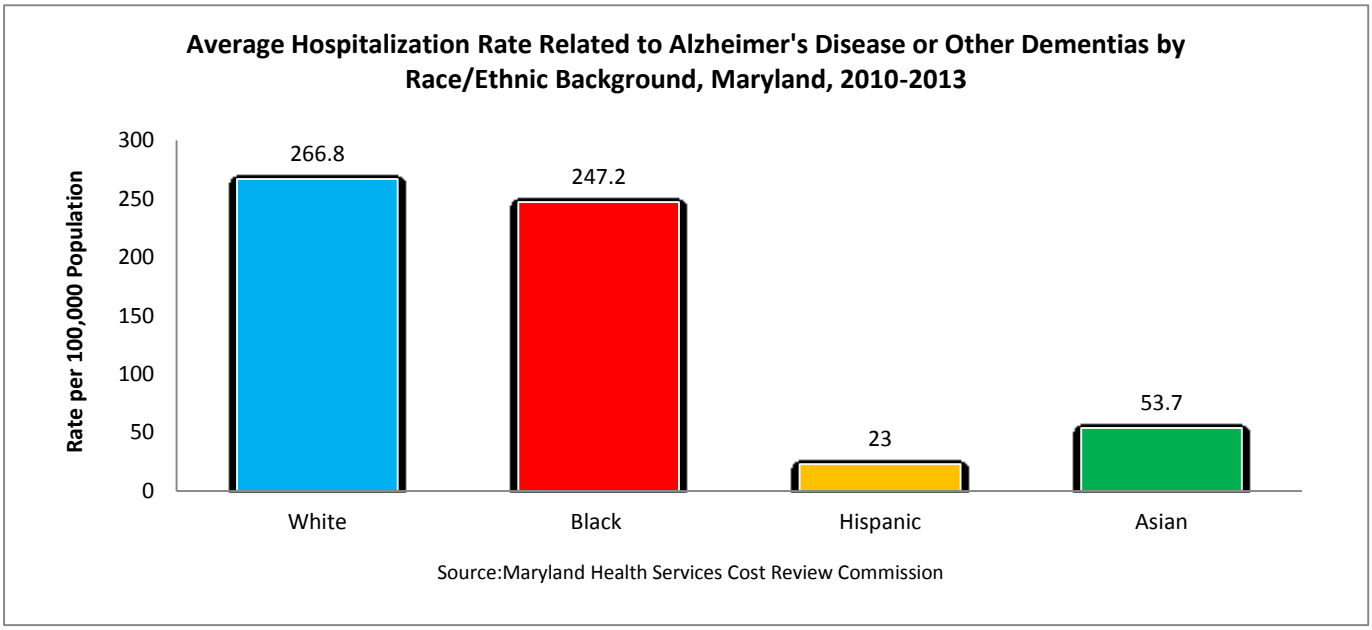
The **Harford County Local Health Improvement Coalition** has worked to improve behavioral health throughout their county. The LHIC's Behavioral Health Workgroup recently hosted a conference "Embracing Change: Behavioral Health Integration" at Harford Community College. The conference, funded by the Maryland Community Health Resources Commission, featured behavioral health experts who provided valuable information to community organizations, program planners, advocates, and other professionals about innovative plans to improve this health priority in the county. Over 150 addictions and mental health professionals attended. The conference introduced upcoming changes at the state level towards the integration of mental health and addictions services and how these changes are expected to improve behavioral health in Harford County.

Hospitalization Rate Due to Alzheimer's Disease or Other Dementias

This indicator shows the rate of hospitalization related to Alzheimer's disease or other dementias (per 100,000 population). In Maryland, approximately 97,000 people are living with Alzheimer's disease. Alzheimer's disease is also the 9th leading cause of death in Maryland. Reducing the proportion of hospitalizations related to Alzheimer's and other dementias can decrease burdens on individuals, families, and the health care system.



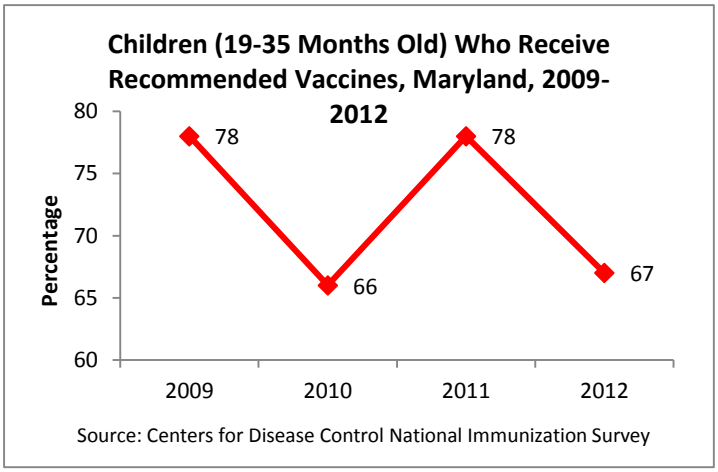
Trends: From 2010 through 2013, the hospitalization rate related to Alzheimer's or other dementias declined significantly. The rate fell from 289.1 to 232.2 per 100,000 between 2010 and 2013 (a 19.7% decline), surpassing the target goal of 274.6. During the same period, the rates declined significantly in all counties with the exception of Calvert, Charles, Garrett, Howard, Kent, and Worcester, where the rates remained relatively stable. Between 2012 and 2013, the rates continued to decline in all counties except Worcester County, where the rate increased significantly from 327.7 to 449.4 per 100,000. The rates among blacks and whites are higher than other races. Between 2010 and 2013, the average rate among blacks was 247.2 per 100,000 and the average rate among whites was 266.8 per 100,000. In contrast, the rates among Asians and Hispanics were 53.7 and 23.0 per 100,000, respectively.



Children Who Receive Recommended Vaccines

This indicator shows the percentage of young children (19-35 months) who received the recommended vaccines. Vaccines are among the most cost-effective clinical preventive services and are a core component of any preventive services package. Increasing vaccination rates can reduce preventable infectious diseases among young children.

Goal: 80.0



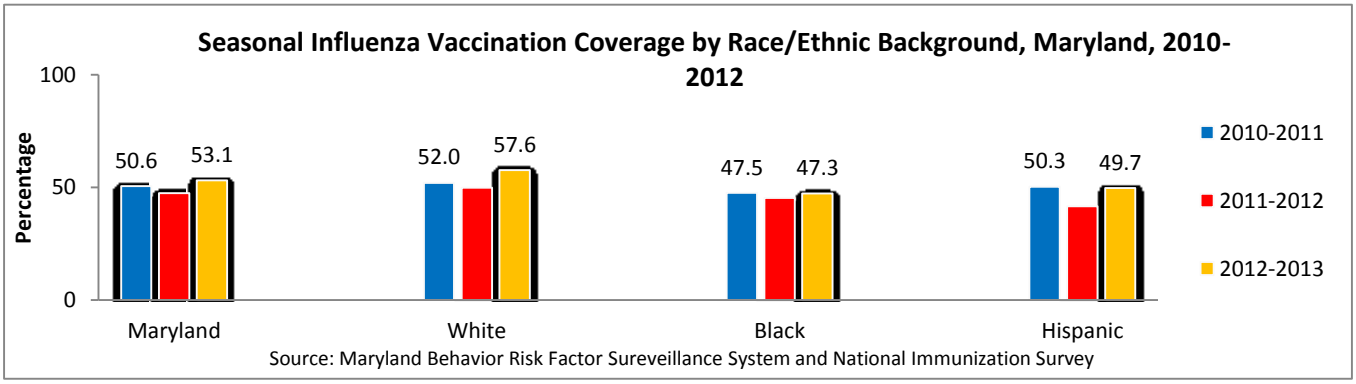
Trends: In 2012, the percentage of children (19-35 months) who received the recommended vaccines (≥4 doses of diphtheria and tetanus toxoids and a cellular pertussis vaccine, ≥3 doses of poliovirus vaccine, ≥1 doses of measles vaccine, full series of Haemophilus influenza type b vaccine, ≥3 doses of hepatitis B vaccine, ≥1 doses of varicella vaccine, and ≥4 doses of pneumococcal conjugate vaccine) was 67.1%. The percentage was slightly lower than the national average of 68.4%. The rates have fluctuated during the past years but have never achieved the target goal of 80%.

Children and Adults Receiving Flu Vaccination

This indicator shows the percentage of children and adults who are vaccinated annually against seasonal influenza. For many people, the seasonal flu is a mild illness, but for some it can lead to pneumonia, hospitalization, or death. Vaccination of persons in high-risk population is especially important to reduce their risk of severe illness or death.

Goal: 65.6

Trends: While generally improving, seasonal flu vaccination among children and adults in Maryland has been lower than the national average. Between 2012 and 2013, the percentage of Marylanders receiving a flu vaccine was 53.1%, 6.2% lower than the national average of 56.6% and well below the state target of 65.6%. The vaccination coverage among blacks and Hispanics has been lower than whites and is one main reason for the low vaccination coverage in Maryland. Currently, Maryland's vaccination coverage is 24.1% lower than the Healthy People 2020's goal of 70%. At the county level, counties in the worst quartile for this measure are Allegany, Caroline, Garrett, Prince George's, St. Mary's, and Somerset.

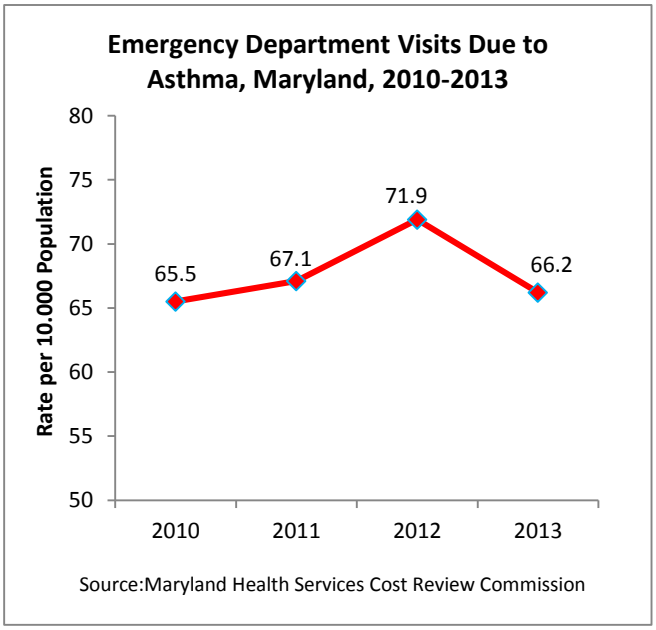


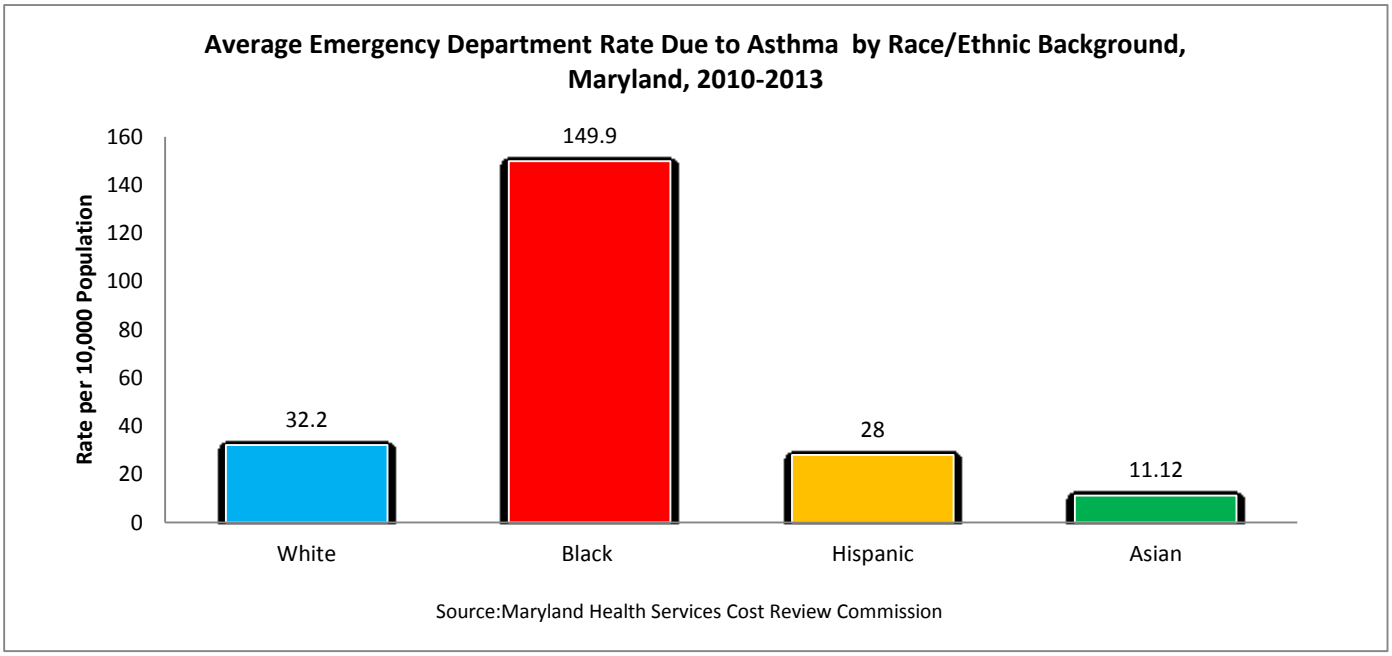
Emergency Department Visits Due to Asthma

This indicator shows the rate of emergency department visits due to asthma per 10,000 population. Asthma is a chronic health condition that causes very serious breathing problems. However, when properly controlled through self-management and medical supervision, individuals and families can manage asthma without costly emergency intervention.

Goal: 52.4

Trends: Overall, the emergency department visit rate due to asthma has remained relatively stable since 2010, always falling well above the target rate of 52.4 per 10,000. The rate was 66.2 per 10,000 population in 2013, a small increase from the rate of 65.5 in 2010. From 2010 to 2013, eight counties (Allegany, Baltimore City, Caroline, Dorchester, Garrett, Kent, Montgomery, and Queen Anne's) had a statistically significant increase in the rate of emergency department visit due to asthma. Between 2012 and 2013, the rates declined in most counties and 13 counties including the state average had statistically significant declines. The data show that blacks are disproportionately affected by asthma. From 2010 through 2013, the emergency department visit rate due to asthma was significantly higher among blacks than whites – the average rate among blacks was 149.9, whereas the rate among whites was 32.2 per 10,000 population.





SHIP IN THE NEWS

The SHIP and activities undertaken by the LHICs have been featured in numerous publications and in local media coverage, a sampling of which is provided below. Full articles are presented in Appendix B.

February 15, 2013. *Garrett County Health Department*. The Healthy Stores Project supports efforts of the Garrett County Health Planning Council by focusing on improving targeted SHIP measures. This community-wide initiative focuses on increasing the proportion of adults and children at a healthy weight and increasing the accessibility and availability of healthy foods. Click here for full story.

March 4, 2013. *Eye on Annapolis*. Anne Arundel County has released a comprehensive Community Health Needs Assessment through the Healthy Anne Arundel Coalition, which has been developed to support the efforts of the SHIP. The needs assessment gathered information about the health needs and health behaviors of county residents by evaluating social determinants of health, mortality rates, risky behaviors, and chronic health conditions. Click here for full story.

April 22, 2013. *Saint Mary's County Health Department*. St. Mary's County Health Department has joined the list of Healthiest Maryland Businesses through its Workplace Wellness initiative designed to improve the health of employees through strategies in the workplace. This initiative was developed to expand and achieve the goals of the SHIP. Click here for full story.

May 3, 2013. *Healthiest Maryland*. The City of Gaithersburg was recently honored as the latest Healthiest Businesses Maryland (HMB) success story. Their workplace wellness success is a great example of how one simple, low-cost strategy can make a big impact on employee health. Click here for full story.

May 14, 2013. *Cumberland Times-News*. Saving people from death or injury because they've overdosed on opioids, whether legal like oxycodone or illegal like heroin, is the focus of a plan being developed by team members at the Allegany County Health Department. Health department members outlined the problem and the rough draft of a plan designed to help save lives at a meeting of the county board of health. The board includes the Allegany County commissioners, who attended the meeting, which took place at health department offices. Click here for full story.

June 25, 2013. *Atlantic General Hospital*. Atlantic General Hospital is the recipient of a $40,000 grant from Perdue Farms to further its efforts to improve the health literacy of Worcester County's youth. They have developed a partnership with the Herschel S. Horowitz Center for Health Literacy at the University of Maryland College Park School of Public Health to draft a set of health literacy standards for the K-8 public school curriculum. No such standards for public schools currently exist in the U.S. Click here for full story.

July 1, 2013. *Baltimore Business Journal*. Harford County and Howard County LHICs received a grant from The Maryland Community Health Resources Commission (CHRC) to address the SHIP measures that have been targeted in their regions. Click here for full story.

August 9, 2013. *Calvert County Public Schools.* Calvert County Public Schools (CCPS) have begun to offer Head Start programs to approximately 172 at-risk three and four-year-olds in the county. CCPS will identify at-risk students based on income status, special learning needs, and other factors. By taking over the program, CCPS is able to provide transportation for students and better align lessons to prepare children for kindergarten. Click here for full story.

September 16, 2013. *Southern Maryland News Net*. The St. Mary's County Health Department offered county residents an opportunity to improve their eating and physical activity habits through the St. Mary's County Alive! Program, an online tool proven to be effective in helping people eat better and be more active. Click here for full story.

October 29, 2013. *Howard County Government*. With 32% of domestic violence victims in Maryland seeking assistance at hospitals, Howard County is expanding services through a hospital-based domestic violence program at Howard County General Hospital. The hospital has partnered with the Domestic Violence Center of Howard County to provide training to nurses and other providers in the hospital's emergency department, labor and delivery unit, and maternal-child unit. Click here for full story.

November 13, 2013. *Baltimore Sun*. Laurel Regional Hospital is planning to expand services to include a one-stop facility dedicated to comprehensive health care for women. The proposed center would include, in one location, specialists from many disciplines including obesity prevention, diabetes management, stress reduction, and mammography screenings. Women are the biggest health care consumers and a comprehensive center for their health care does not exist in Prince George's County. Click here for full story.

December 2, 2013. *Baltimore Sun*. Howard County recently opened its first school-based wellness center at Bollman Bridge Elementary School. The center is staffed by the Howard County Health Department and includes a full-time pediatric nurse practitioner, a medical office assistant, a licensed social worker, and a part-time pediatrician. Available services include health assessments, immunizations, and physicals for athletic activities. Click here for full story.

January 18, 2014. *Baltimore Sun*. Howard County Health Department, along with nonprofit Healthy Howard, partnered to launch a regional health initiative aimed at decreasing the availability of sugary drinks while increasing the affordability of fruits and vegetables, physical activity and access to affordable health care. Click here for full story.

February 24, 2014. *Delmarva Now*. Worcester County Public Schools is on the leading edge of helping to develop and teach health literacy — a new comprehensive health education state curriculum. Their school system, in partnership with Atlantic General Hospital, is working on an Integrated Health Literacy pilot-program at Ocean City Elementary School. This program is supported by a grant from the Arthur W. Perdue Foundation and receives additional guidance from the University of Maryland Center for Health Literacy. Click here for full story.

February 26, 2014. *Baltimore City Health Department*. A $750,000 three-year state grant awarded this month will enable the Baltimore City Health Department to expand efforts at reducing childhood obesity by launching a Baltimarket Healthy Stores program addressing food inequities for residents living in food deserts. Baltimarket

Healthy Stores will reach 12,100 people during the three year period by supporting 18 corner stores in successfully stocking healthier items. Click here for full story.

March 12, 2014. *The Washington Informer*. A new program designed to expand medical services in underserved communities has residents in the Capitol Heights area of Prince George's County on the road to wellness, after the opening of a state-of-the-art medical facility. Capitol Heights was selected last year as one of the first Health Enterprise Zones (HEZ) in Maryland, which identifies communities with economic disadvantages and inadequate access to health care for assistance in expanding medical services. See Click here for full story.

April 9, 2014. *Dimensions Healthcare System*. Prince George's Hospital Center has achieved "Top Perfomer" status for the fourth quarter of 2013 as part of the Maryland Hospital Hand Hygiene Collaborative. Hospitals, that are considered top performers, have a minimum 90% overall hand hygiene compliance rate for three consecutive months. Click here for full story.

June 17, 2014. *The Baltimore Sun*. Howard County is creating a task force charged with developing a comprehensive behavioral health action plan for the county — one that officials say is needed, in part, in response to the January shooting deaths at The Mall in Columbia. County officials said goals for the Behavioral Health Action Plan Task Force include assessing what community groups now provide to support those with mental illness, identifying gaps in care, and providing policy, program and funding recommendations. Click here for full story.

August 4, 2014. *LifeBridge Health*. Sinai Hospital of Baltimore and HealthCare Access Maryland are piloting a groundbreaking program developed to proactively help patients, who frequently use the hospital's Emergency Department for non-urgent and chronic health conditions, better manage their own care, lead healthier lives, and in turn, save precious health-related resources. Click here for full story.

August 13, 2014. *Carroll County Times*. Maryland hospitals are outpacing Gov. Martin O'Malley's goals for reducing the cost of care in the state, and Carroll Hospital Center is one of the hospitals leading the pack. At Carroll Hospital Center, changes have been made to increase both quality and efficiency of care, as well as increasing the focus on preventive care. Case managers in the emergency department and service navigators now help guide patients to the most appropriate care, oftentimes outside the more expensive hospital setting. Click here for full story.

September 22, 2014. *Howard County Government*. There is a groundbreaking initiative in five Howard County schools that will use telemedicine technology to boost health and student performance. County health officials say this is the first school-based wellness center using telemedicine in the state of Maryland, and is designed to improve access to health care for pupils, reduce absences due to medical conditions, and improve educational outcomes. Click here for full story.

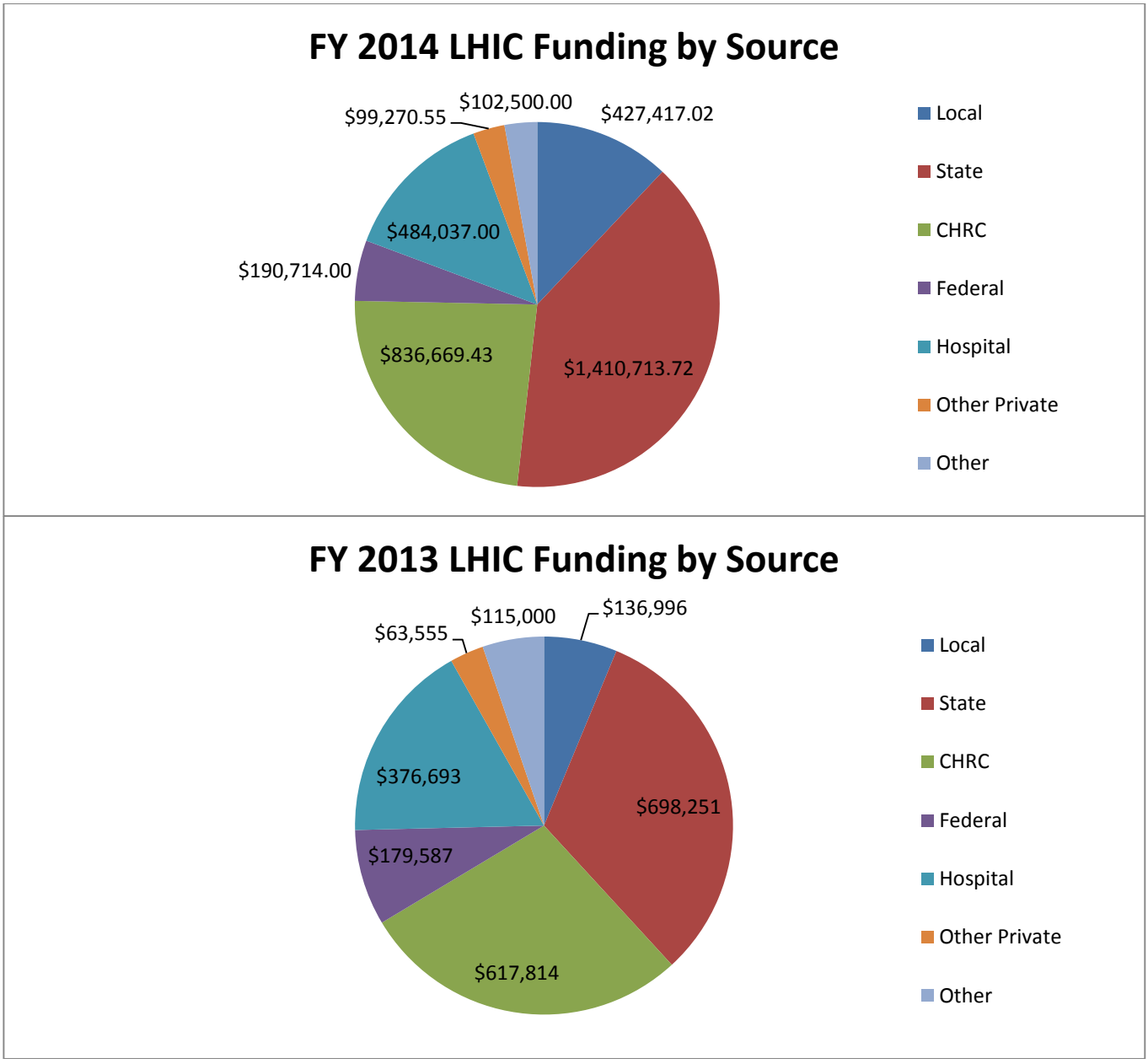
October 1, 2014. *University of Maryland School of Public Health*. On October 1, School of Public Health students launched the "Lose It to Win It" campaign to motivate Prince George's County residents to lose weight. Their goal is to get at least 250,000 residents to lose four pounds each, so that the county collectively loses one million pounds in one year. With heart disease the leading cause of death among adults in the county, the weight loss challenge is designed to engage participants in behaviors that improve their diet and fitness level, thus lowering their risk, via educational and motivational text messages. See Click here for full story.

APPENDIX: LHIC PRIORITIES AND FINANCES

Sources of Funding

Year One funding for LHIC establishment and development was primarily supported through a partnership with the Maryland Hospital Association. The Year Two and Year Three financial summary update show that LHICs are now predominantly supported through state funding. As a result of the collective investment from state, federal, local hospital, Maryland Community Health Resources Commission (CHRC), and private funding, every LHIC made significant progress towards their 2014 SHIP goals.

The LHICs have used funding from hospitals; local, state, and federal allocations; the Community Health Resources Commission and private entities to launch action to address targeted health priorities.



2013 Priority Areas and Financial Summary

County	Total Funding	Total Funding by Source			Spending Highlights	Priority Areas
Allegany 2013	$193,285	Public Funding	Local	$11,577	· Support planning activities. · Implementation progress. · Manage the LHIC Web site. · Maintain fiscal records and reports. · Support coalition activities. · Prepare for and facilitate LHIC Board Meetings. · Health fairs for screenings, drinking & driving awareness events. · Four permanent medicine drop off sites with a social media campaign. · Incentives, equipment and promotion of Mile Movers, Worksite grants, and Healthy Vending. · Social support initiatives to promote smoke-free parks, implement smoke-free initiatives in multi-unit housing, increase awareness of the dangers of secondhand smoke, promote breastfeeding friendly policies, increase physical activity opportunities in schools, and improve nutrition and physical activity practices in child care settings.	· Tobacco · Obesity · Access to Care · Emotional/Mental Health · Substance Abuse Screening · Health Literacy · Healthy Start · Immunizations · Chronic Respiratory Disease
			State	$16,743		
			CHRC	$25,000		
			Federal	$62,500		
		Private Funding	Hospital	$56,755		
			Other Private	$20,730		
		Other		----		
Allegany 2014	$391,597	Public Funding	Local	$28,500	· Community health needs assessment · Local Health Action Plan (LHAP) development · Program implementation · Policy and environmental change to promote health · Manage LHIC website · Support subgroup activities (ex. tobacco, transportation) · Report progress on LHAP and health indicators	· Tobacco · Obesity · Access to Care · Emotional and Mental Health · Substance Abuse · Screening · Heart Disease and Stroke
			State	$3,000		
			CHRC	$185,048		
			Federal	$84,411		

		Private Funding	Hospital	$70,567		· Health Literacy · Healthy Start · Dental · Cancer · Immunizations · Chronic Respiratory Disease
			Other Private	$20,071		
		Other		0		
Anne Arundel 2013	$105,800	Public Funding	Local	$1,825	· Approximately $55,000 of FY12 funds were spent in FY13 to support the Coalition's Community Health Needs Assessment, the County's Mental Health Needs Assessment and mini-grants for obesity prevention. · The Coalition was supported primarily by in-kind staff ($100,000) in FY13.	· Obesity Prevention · Prevention and Management of Co-Occurring Disorders
			State	----		
			CHRC	----		
			Federal	----		
		Private Funding	Hospital	$3,325		
			Other Private	$650		
		Other		$100,000		
Anne Arundel 2014	$123,160	Public Funding	Local	$800	· Promotional and public information supplies and materials to support the coalition. $3,670 for meetings. $16,100 Jurisdictional Training for ASAM Criteria $2,500 Jurisdictional Training Stages of Change/Motivational Enhancement Note: Approx. $9,800 of State PHHS encumbered in FY13, but spent in FY14 to support the development of Healthy Events and Meeting resources.	· Obesity Prevention · Prevention and Management of Co-Occurring Disorders
			State	$22,360		
			CHRC	$0		
			Federal	$0		
		Private Funding	Hospital	$0		
			Other Private	$0		

		Other		$100,000	· The Coalition was supported by in-kind health department staff (approx. $100,000) in FY14.	
Baltimore City 2013	$5,200	Public Funding	Local	$2,200	· Promoting heart health. · Redesigning communities to prevent obesity. · Freedom from tobacco use.	· Access to Care · Tobacco · Obesity Prevention · Heart Health · HIV & STD Prevention · Mental Health · Alcohol Abuse · Cancer
			State	----		
			CHRC	----		
			Federal	----		
		Private Funding	Hospital	----		
			Other Private	$3,000		
		Other		----		
Baltimore City 2014	$15,000	Public Funding	Local	$15,000	· In-kind/BCHD staff prepare and facilitate Baltimore City HIPC (LHIC) Meetings (3) · Strategic Planning Efforts · Community Health Event (1)	· Promoting heart health. · Redesigning communities to prevent obesity. · Freedom from tobacco use.
			State			
			CHRC			
			Federal			
		Private Funding	Hospital			
			Other Private			
		Other				
Baltimore County 2013	$100,000	Public Funding	Local	----	· Educational programs. · Activities in senior centers, libraries, churches. · Partnerships with St. Agnes' Perinatal Low Birth Weight Program. · Community Health Needs Assessment in progress	· Physical Activity · Low Birth Weight · Tobacco
			State	----		
			CHRC	$25,000		
			Federal	----		
			Hospital	$75,000		

		Private Funding	Other Private	----		
		Other		----		
Baltimore County 2014	$0	Public Funding	Local	0	· In Kind salary Administrator and Administrative support staff	Physical Activity
			State	0	· Community Health Needs Assessment	Low Birth Weight
			CHRC	$0	· Tobacco grants to schools and education	Tobacco
			Federal	0	· Coalition presenters and education	Reduce HTN ER visits
		Private Funding	Hospital		· Grand Rounds premature labor	Substance Abuse Overdose
			Other Private	0	· Partner with Northwest Changing Hearts	
		Other			· Healthy Babies Collaborative Franklin Square	
Calvert 2013	$589,789	Public Funding	Local	----	· Smoking cessation classes and Quit line calls. · Free Nutrition and weight loss programs. · Free diabetes, cholesterol and cancer screenings. · Developed community coordination care team model. · Developed Diabetes Survival Guide, Diabetes Boot Camp community education program.	· Tobacco · Obesity · Cancer Deaths · Heart Disease deaths · Diabetes ED Visits
			State	$344,954	· Dental Clinic:	· Hypertension ED Visits
			CHRC	$50,000	· Evaluation of adult dental ER visits to navigate to appropriate level of care and improved outcomes.	· Ability to Afford Care
			Federal	$43,322	· Provide emergency adult care for dental exams and extractions through Mission of Mercy.	
		Private Funding	Hospital	$121,513	· Provide community Oral Cancer Screenings and outreach education.	
			Other Private	$30,000	· Improve access to MA children for preventative exams, cleanings and sealants.	
		Other		----	· Provide school based screenings in partnership with Judy Center and Head Start.	
Calvert 2014	$516,211	Public Funding	Local	0.00	· Smoking cessation classes and quit line calls.	· Smoking
			State	338,905.00	· PATCH program and no smoking campuses.	· Obesity

			CHRC		· Breathe Free / Calvert Can county initiative	· Cancer Deaths
			Federal	19,136.00	· Provide Free Nutrition and weight loss programs	· Heart Disease deaths
		Private Funding	Hospital	128,170.00	· Provide Free Vascular, Cholesterol, PSA, hbA1c, Skin Cancer, Oral Cancer and Colorectal cancer screenings programs	· Disparities
			Other Private	30,000.00	· Free Blood pressure screenings, health risk assessments, health fairs, education seminars and support groups.	
		Other			· RN Diabetes Educator developed education packet for ED staff and coordinate care with Transitions Nurse and case manager to navigate patients to appropriate levels of care and remove barriers in accessing care.	
Carroll 2013	$163,100	Public Funding	Local	$43,000	· Staff.	· Behavioral Health
			State	----	· Coalition support.	· Oral Health
			CHRC	----	· Decreased behavioral health emergency department visits.	· Tobacco
			Federal	----		· Nutrition (Obesity and Salmonella)
		Private Funding	Hospital	$120,100		· Cancer
			Other Private	----		· Heart Disease
		Other		----		
Carroll 2014	$201,000	Public Funding	Local	$50,000	· LHIC Staff	· Behavioral
			State	0		· Oral Health
			CHRC	0		· Tobacco
			Federal	0		· Nutrition (Obesity and Salmonella)
		Private Funding	Hospital	$151,000	· LHIC Structure/Coalition Support	· Cancer
			Other Private	0		· Heart Disease
		Other		0		

Cecil 2013	$50,000	Public Funding	Local	20,000	· Hired a substance abuse consultant (Health Resources in Action, Boston, MA). · Provided an in depth analysis of the substance abuse issue in Cecil County. · The consultant's report was recently released detailing the breadth of the issue, as well as providing recommendations for prevention, treatment and recovery, provider education, and enforcement in Cecil County. · The Cecil County LHIC is now taking the necessary next steps to follow these recommendations. · The consultant's report may be accessed here: http://www.cecilcountyhealth.org/ccdhxx/pdf/072613_HRiA_Report_Tackles_County_Substance_Abuse.pdf	· Prescription Drug Abuse · Mental Health · Substance Abuse Prevention · Childhood Obesity · Child Abuse
			State	----		
			CHRC	25,000		
			Federal	----		
		Private Funding	Hospital	----		
			Other Private	5,000		
		Other		----		
Cecil 2014	$38,634	Public Funding	Local	11,334	· Dedicated staff to coordinate LHIC activities. · Planning and facilitating LHIC meetings and activates. · Educational activities on priority areas. · Provision of guidance for grant activities · Addition of Chronic Disease Plan to the LHIP · Awarded 5 tobacco-use prevention mini-grants	· Prescription Drug Abuse · Mental Health · Substance Abuse Prevention · Childhood Obesity · Child Abuse · Chronic Disease
			State	$3,000		
			CHRC			
			Federal			
		Private Funding	Hospital (in kind)	$24,300		
			Other Private			
		Other				
Charles 2013	$256,716	Public Funding	Local	$2,554	· Mall Banner to provide information on free/low cost dental and health services in county. · Establish the Anti-Tobacco Advocate Program in schools.	· Lung Cancer · Prostate Cancer

					· Charles County Cancer Resource Guide. · Prostate Cancer Educational Campaigns.	· Heart Disease Mortality · Obesity
			State	$119,699	· Healthy Stores, School Wellness Champions.	· Diabetes Morbidity/Mortality
			CHRC	----	· Youth Triathlon, Jump with Jill at the fair, Community events.	· Access to Care
			Federal	$73,765	· Community-wide awareness campaign with billboards, ads, VanGo signs for mental health.	· Substance Abuse
		Private Funding	Hospital	$56,522	· Mental Health First Aid trainer course and subsequent trainings in community.	· Mental Health
			Other Private	$4,175	· Party patrol training and surveillance, Project Graduation (drug-free event), Transition Presentations.	
		Other		----	· New materials on opiate addiction.	
Charles 2014	$610,769	Public Funding	Local	$55,000	· Implemented the Million Hearts Initiative through blood pressure screenings in the community. · Established Western County Family Medical Center, a patient centered medical home in the western region of the county. · Expanded dental health services for adults at the health department clinic and the Southern Maryland Mission of Mercy. Also increased sealant program in schools. · Inflatable colon display for outreach and education on colorectal cancer.	· Lung Cancer · Prostate and Colorectal Cancers · Heart Disease Mortality · Obesity
			State	$181,602	· Healthy Stores, School Wellness Champions, Maryland Healthiest Businesses.	· Diabetes Morbidity/Mortality
			CHRC	$225,000	· Youth Triathlon, Obesity Prevention at Charles County Fair, Community events.	· Access to Care
			Federal	$87,167	· Community-wide awareness campaign with VanGo bus wraps for underage drinking and suicide prevention.	· Substance Abuse
		Private Funding	Hospital	$45,000	· Mental Health First Aid trainings in community.	· Mental Health
			Other Private	$17,000	· A community listening session to address opiates and substance abuse in Charles County.	· Minority Infant Mortality

		Other		0	Established minority infant mortality reduction program.	· Dental Health
Frederick 2013	$80,075	Public Funding	Local (Grant, Contributions and In-kind staff time)	$30,075	· The Frederick County Health Access Program utilized all FY12 available funding and FY13 funding from the Community Foundation of Frederick County ($21,175 FY 13). · The Women's Giving Circle of Frederick County ($7,000) and a private donation ($1,900) in providing care coordination and paying for medical care for uninsured persons with low incomes who are not eligible for existing public insurance programs or the type of care needed is not covered by the public insurance programs such as specialty care for PAC enrollees. · Fifty-five new persons were enrolled for a total active enrollment during the year of 185 persons who received almost $185,000 in physician donated care (292 primary care office visits and 209 subspecialist visits) leveraged by the grant funding to cover non-physician charges associated with primary care and subspecialty care visits and prescriptions.	· Tobacco Free Living · Active Living · Healthy Eating · Clinical and Community Preventive Services · Program Infrastructure
			State	----		
			MCHRC	$50,000		
			Federal	----		
		Private Funding	Hospital	In-kind staff time from FMH and Maryland Hospital Association		
			Other Private			
		Other		----		

Frederick 2014	$3,775	Public Funding	Local (Grant, Contributions and In-kind staff time)	$3,775	· The Frederick County Health Access Program utilized all FY14 funding from the Community Foundation of Frederick County of $3,200 and $575 private donations providing care coordination and paying for medical care for uninsured persons with low incomes who are not eligible for existing public insurance programs or the type of care needed is not covered by the public insurance programs such as specialty care for PAC enrollees . · In FY 14, 16 new persons were enrolled for a total active enrollment during the year of 201 persons who received almost $67,000 in physician donated care (30 primary care office visits and 50 subspecialist visits) leveraged by the grant funding to cover non-physician charges associated with primary care and subspecialty care visits and prescriptions. In addition, $6,332 of the MHA grant was used for infrastructure and staff support.	
			State			
			CHRC			
			Federal			
		Private Funding	Hospital	In-kind staff time from FMH and Maryland Hospital Association		
			Other Private			
		Other				
Garrett 2013	$40,000	Public Funding	Local	----	· Farm to Head Start. · Healthy Stores Project. · Healthy Restaurants Project.	· Obesity Prevention
			State	----		
			CHRC	$25,000		
			Federal	----		
		Private Funding	Hospital	----		
			Other Private	----		
		Other		$15,000		
Garrett 2014	$168,000	Public Funding	Local		· Community Transformation Grant and Cigarette Restitution Fund Program	Obesity Prevention, Tobacco Prevention, Flu Vaccine
			State	$168,000		

			CHRC		· Worksite wellness with 5 businesses	
			Federal		· School wellness with 4 Title 1 schools	
		Private Funding	Hospital		· Cessation for youth, adults and pregnant women	
			Other Private		· Community campaign on spit tobacco prevention	
		Other				
Harford 2013	$144,355	Public Funding	Local	----	· School Wellness Programming.	· Obesity Prevention
			State	$94,355	· Healthy Harford marketing plan.	· Tobacco Cessation
			CHRC	$50,000	· Embracing Change Behavioral Health Integration Conference.	· Behavioral Health
			Federal	----	· Text message pilot program.	
		Private Funding	Hospital	----		
			Other Private	----		
		Other		----		
Harford 2014	$65,975	Public Funding	Local	----	· Child care trainings.	· Obesity Prevention
			State	$65,975	· Anti-tobacco marketing campaign.	· Tobacco Cessation
			CHRC	----	· Healthy Harford designation programs and resources.	· Behavioral Health
			Federal	----		
		Private Funding	Hospital	----		
			Other Private	----		
		Other		----		
Howard 2013	$47,500	Public Funding	Local	----	· Implemented a new health survey. The following materials were developed to enhance dissemination to potential partners, stakeholders, and the public: www.howardcountyhealthsurvey.com.	· Access to Care
			State	$47,500	· Developed outreach materials to inform potential partners, stakeholders, and the public.	· Behavioral Health
			CHRC		· Planning and facilitation of beginning LHIC meetings by consultant.	· Healthy Weight

			Federal	----	· Howard County Health Assessment Survey "Answer the Call!" campaign.	
		Private Funding	Hospital	----		
			Other Private	----		
		Other		----		
Howard 2014	$417,500	Public Funding	Local	$212,500	· Fielded second round of Howard County Health Assessment Survey with three partner organizations, including the hospital	· Healthy Weight · Access to Care · Behavioral Health
			State	$47,500	· Hired staff for LHIC, completed LHIC redirection	
			CHRC	$125,000	· Piloted CIMH project that includes Community Care Team and Patient Centered Medical Home collaborative learning program	
			Federal		· Healthy Weight : Worked on committee to revise school system Wellness Policy, which recently scored an "A" from Yale University Rudd Center for Food Policy and Obesity. Supported development of the Childhood Obesity Prevention Toolkit for health care providers, and assisted with recruitment of providers for CME events.	
		Private Funding	Hospital	$2,500	· Access to Care: Supported the promotion of 211 as a referral resource for Howard County residents. Participated in the development and promotion of the Howard County Health Assessment Survey. Helped to create the Community Integrated Medical Home, a project to improve access to care for residents with multiple chronic conditions who have had unnecessary hospitalizations.	
			Other Private	$30,000	Behavioral Health: Analyzed data on behavioral health hospital visits to identify gaps in services. Creating a care continuum of behavioral health services available in Howard County.	
		Other				
Mid Shore 2013	$0	Public Funding	Local	----	· FY12 Funding used to support FY13 action.	· Adolescent Obesity
			State	----	· Funding for Health Enterprise Zone Proposal.	· Adolescent Smoking

			CHRC	----	· Funding for Network Planning Grant Proposal.	· Diabetic Emergency Room Visits · Behavioral Health Emergency Room Visits
			Federal	----		
		Private Funding	Hospital	----		
			Other Private	----		
		Other		----		
Mid Shore 2014	$178,055	Public Funding	Local		Regional Community Health Outreach Worker and Community Based Chronic Disease Prevention Program	Unchanged from FY 13
			State	178,055		
			CHRC			
			Federal			
		Private Funding	Hospital			
			Other Private			
		Other				
Montgomery 2013	$103,814	Public Funding	Local	$23,500	· Continued contract with HCI to maintain HM Web site.	· Behavioral Health
			State	----	· Utilized hospital funding to recruit an experienced program manager for HM; balance will support additional administrative staff.	· Cancer
			CHRC	$17,814	· CHRC funds will continue to enhance the work hours of an existing HM employee; providing support to ongoing work group sessions.	· Cardiovascular Health
			Federal	----	· Completion of the two issue areas currently underway; leading to the implementation phase of HM.	· Diabetes
		Private Funding	Hospital	$62,500	· Utilized hospital funding to support an experienced program manager for HM; balance supports additional administrative staff. Next steps: initiation of the remaining issue areas within Montgomery County.	· Maternal and Infant Health

			Other Private	----		· Obesity
		Other		----		
Montgomery 2014	$100,121	Public Funding	Local	$23,500	· Continued contract with HCI to maintain HM Web site.	· Behavioral Health
			State			· Cancer
			CHRC	$14,121	· CHRC funds to support the implementation of the behavioral health action plan and the obesity action plans including staffing for behavioral health navigators.	· Cardiovascular Health
			Federal			· Diabetes
		Private Funding	Hospital	$62,500	· Utilized hospital funding to support an experienced program manager for HM; balance supports additional administrative staff. Next steps: initiation of the remaining issue areas within Montgomery County.	· Maternal and Infant Health
			Other Private		· Completion of the two issue areas currently underway; leading to the implementation phase of HM.	· Obesity
		Other				
Prince George's 2013	$100,000	Public Funding	Local	----	· At a Glance Community Guide.	· Access to Health Care
			State	$ 75,000	· Chronic Disease Toolkit.	· Chronic Disease
			CHRC	$ 25,000	· KISS (Keeping it Sexually Safe) Web site.	· HIV, STI Prevention
			Federal	----	· Bilingual 'Are You Pregnant?' Card.	· Infant Mortality
		Private Funding	Hospital	----	· Infant Mortality Prevention Cribs.	· Infant Mortality
			Other Private	----	· GIS Mapping Software.	· Chronic Disease
		Other		----	· HIV Focus Group Cards.	· HIV, STI Prevention
Prince George's 2014	$ 125,217	Public Funding	Local	$ 22,683	· HIV Doctors, Clinicians Symposium	· STD/STI Prevention
			State	$ 97,834	· Healthy Eating Workshops	· Chronic Disease
			CHRC	$ -	· CHWs for community outreach, maternal health care	· Infant Mortality
			Federal	$ -	· Bilingual pregnancy information cards	· Access to Health Care

		Private Funding	Hospital	$ -	· Domestic Violence self-assessment tools	· Domestic Violence
			Other Private	$ 2,200		
		Other		$ 2,500		
Saint Mary's 2013	$2,265	Public Funding	Local	$2,265	· Coalition development. · Digital marketing. · Web site development.	· Healthy Eating and Active Living · Tobacco-free Living · Behavioral Health · Access to Care
			State	----		
			CHRC	----		
			Federal	----		
		Private Funding	Hospital	----		
			Other Private	----		
		Other		----		
Saint Mary's 2014	$61,200	Public Funding	Local	$4,325	· Web site development and Alive! Program · Healthier Schools, Tobacco Free Living · Workplace Wellness, Let's Move Childcare	· Healthy Eating and Active Living · Tobacco-free Living · Behavioral Health · Access to Care
			State	$56,875		
			CHRC			
			Federal			
		Private Funding	Hospital			
			Other Private			
		Other				
Somerset 2014	$207,008	Public Funding	Local		· Promote active living, healthy eating and smoke free environments. · Reduce/prevent childhood obesity · Reduce/prevent diabetes.	· Health Promotion/Wellness · Diabetes · Obesity · Tobacco
			State	$169,508		
			CHRC	$37,500		
			Federal			
		Private Funding	Hospital			
			Other Private			
		Other				

Tri-County 2013 (Somerset, Wicomico, Worcester)	$75,000	Public Funding	Local	----	· U.S. Department of Housing & Rural Development grants. · Programs to support family planning, behavioral health, communicable disease, environmental health, and prevention.	· Family Planning · Behavioral Health Promotion · Environmental Hεαlτη · Communicable Diseases · Homeless Population
			State	----		
			CHRC	$75,000		
			Federal	----		
		Private Funding	Hospital	----		
			Other Private	----		
		Other		----		
Washington 2013	$18,500	Public Funding	Local	----	· Community needs assessment. · Chronic disease self-management program. · Development of QI measures.	· Chronic disease control · Mental health accessibility
			State	$9,250		
			CHRC	----		
			Federal	----		
		Private Funding	Hospital	$9,250		
			Other Private	----		
		Other		----		
Washington 2014	$0	Public Funding	Local	0	n/a	n/a
			State	0		
			CHRC	0		
			Federal	0		
		Private Funding	Hospital	0		
			Other Private	0		
		Other				
Wicomico County 2014	$84, 362	Public Funding	Local	$0	· Community Transformation Grant (approx.. 2/3 funding to support obesity prevention initiatives).	· Asthma · Behavioral Health
			State	$84, 362		

			CHRC	See Worc. Co/Tri-County	· Worksite Wellness HMB (100% funding to support obesity and diabetes prevention).	· Diabetes · Obesity · Sexually Transmitted Infections (STIs)
			Federal	$0		
		Private Funding	Hospital	$0		
			Other Private	$0		
		Other				
Worcester 2014	$328,100	Public Funding	Local		· CTG/PHHS: Healthy Lifestyles · MD Healthiest Workplaces · TRI-COUNTY RN home visiting program to improve management of diabetes and decrease ER visits · Programs to support healthy lifestyle (Just Walk, Fun Walks, Tobacco cessation, worksite wellness) , behavioral health, communicable disease, environmental health, and prevention.	· Healthy Lifestyles · Access to Care · Promoting Behavioral Health · Communicable Diseases
			State*	$78,100		
			CHRC	250,000		
			Federal			
		Private Funding	Hospital			
			Other Private			
		Other				